

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## • 1491 CERTIFICATE OF DEATH

01300

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

COUNTY Baldo MARYLAND  
 CITY (If outside corporate limits, write RURAL  
 OR and give nearest town)  
 TOWN Lutherville LENGTH OF STAY  
 (in this place)

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS College Manor Nursing Ho.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN Baltimore 18  
 STREET ADDRESS  
 (If rural give location)  
Northway Apts.

3. NAME OF  
 DECEASED:  
 (Type or Print)(First) MAUDE(Middle) WILSON(Last) ADAMS4. DATE (Month)  
 OF DEATH: Feb. 14, (Day) 19 (Year) 565. SEX:  
 female6. COLOR OR  
 RACE:  
 white7. SINGLE, MARRIED,  
 WIDOWED, DIVORCED.  
 (Specify) widowed8. DATE OF BIRTH:  
Nov. 21, 18719. AGE last birthday  
84 yrs.IF UNDER 1 YEAR  
 Months 0 Days 0 Hours 0 Min. 010A. USUAL OCCUPATION (Give kind of  
 work done during most of working life,  
 even if retired): ?10B. KIND OF BUSINESS  
 OR INDUSTRY:11. BIRTHPLACE (State or foreign country): Missouri 12. CITIZEN OF WHAT  
 COUNTRY?

## 13. FATHER'S NAME:

George Williams

## 14. MOTHER'S MAIDEN NAME:

Harriette Hancock15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
 (Yes, no, or unk.) (If Yes, give war or dates  
 of service)

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS:

Mrs. Alberta W. Lenzen-Northway Apts.18. MEDICAL CERTIFICATION  
 I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATHINTERVAL BETWEEN  
 ONSET AND DEATH4/20/56  
 IMMEDIATE CAUSE(A)  
 DUE TOArterio - Sclerotic Heart Disease5 yrs.

ANTECEDENT CAUSE (S):

(B)  
 DUE TOCerebral arterio - sclerosis2 years

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
 YES  NO None21A. ACCIDENT WAS UNDERLYING  OR  
 CONTRIBUTING  CAUSE OF DEATH  
 (If either, notify medical examiner)21B. PLACE (Home, farm, factory,  
 OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
 INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
 OF INJURY

## 21E. INJURY OCCURRED

## 21F. HOW DID INJURY OCCUR?

M. While  
 at work  Not while  
 at work 22. I hereby certify that I attended the deceased from JUNE, 1951, to Feb. 14, 1956 that I last saw the deceased  
 alive on Dec. 15, 1955, and that death occurred at 11:00 A.M. from the causes and on the date stated above.  
 SIGNATURE Crawford N. Kilpatrick Jr. M.D. ADDRESS 6 E. Eager St. Baltimore 2-1121 DATE SIGNED23. BURIAL, CREMATION, DATE THEREOF  
 REMOVAL (SPECIFY)DATE THEREOF  
2/17/56NAME OF CEMETERY OR CREMATORIUM  
Druid Ridge Cem.LOCATION (City, town, or county)  
Pikesville, Md.

(State)

Burial

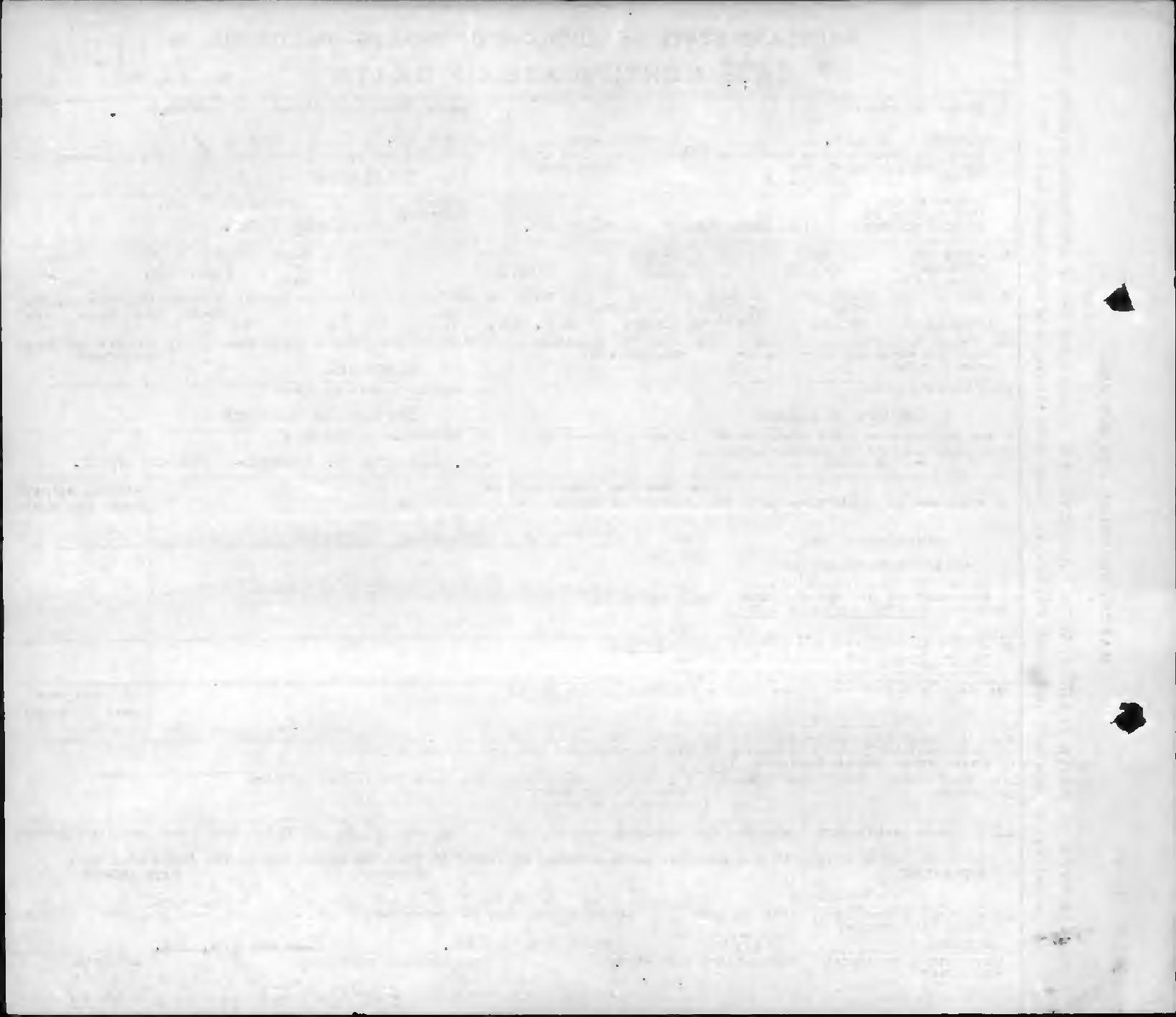
DATE REC'D BY LOCAL  
 REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

16-587-2M. J. Lichtenhous Balt 17



01361

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1402 CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

COUNTY Balto

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)TOWN Glenarm P.O.LENGTH OF STAY  
(in this place)

25 yrs

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESSLong Green Md

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MdCOUNTY BaltoCITY (If outside corporate limits, write RURAL and give nearest town)  
ORTOWN Glenarm P.O.

(If rural give location)

STREET  
ADDRESSLong Green Md3. NAME OF  
DECEASED:  
(Type or Print)(First) Eleanora(Middle) (Last) Albrecht4. DATE (Month) Feb (Day) 19 (Year) 1956OF  
DEATH:5. SEX: Female6. COLOR OR White7. SINGLED, MARRIED, MARRIEDWIDOWED, DIVORCED, (Specify): 8. DATE OF BIRTH: Jan 31-18729. AGE last birthday: 84 yrs.

IF UNDER 1 YEAR

Months  Days  Hours  Min. 10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired): At Home Housekeeper10B. KIND OF BUSINESS  
OR INDUSTRY: 11. BIRTHPLACE (State or foreign country): Balto Md12. CITIZEN OF WHAT  
COUNTRY? USA13. FATHER'S NAME: Philip A Albrecht14. MOTHER'S MAIDEN NAME: Eleanora Tegemann

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unk.) (If Yes, give war or dates  
of service) No16. SOCIAL SECURITY NO. None17. INFORMANT & ADDRESS: Mr Chas A Albrecht, Glenarm P.O.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

IMMEDIATE CAUSE

(A) DUE

(B) DUE TO

(C)

Congestive Heart Failure

Arteriosclerotic Heart Dis. 2 yr.

INTERVAL BETWEEN  
ONSET AND DEATH 10 mos.II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.19A. DATE OF OPERATION: 

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO OR CONTRIBUTING CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,  
street, office bldg. etc.) OF INJURY21C. WHERE DID (City or town)  
INJURY OCCUR?(County)  (State) 

21D. TIME (Month) (Day) (Year) (Hour)

OF INJURY 21E. INJURY OCCURRED  
While  Not while M. at work  at work 

21F. HOW DID INJURY OCCUR?

Dr. Clifford Hudson  
Fork Rd.



BUREAU U. S.

MAR 7 1956

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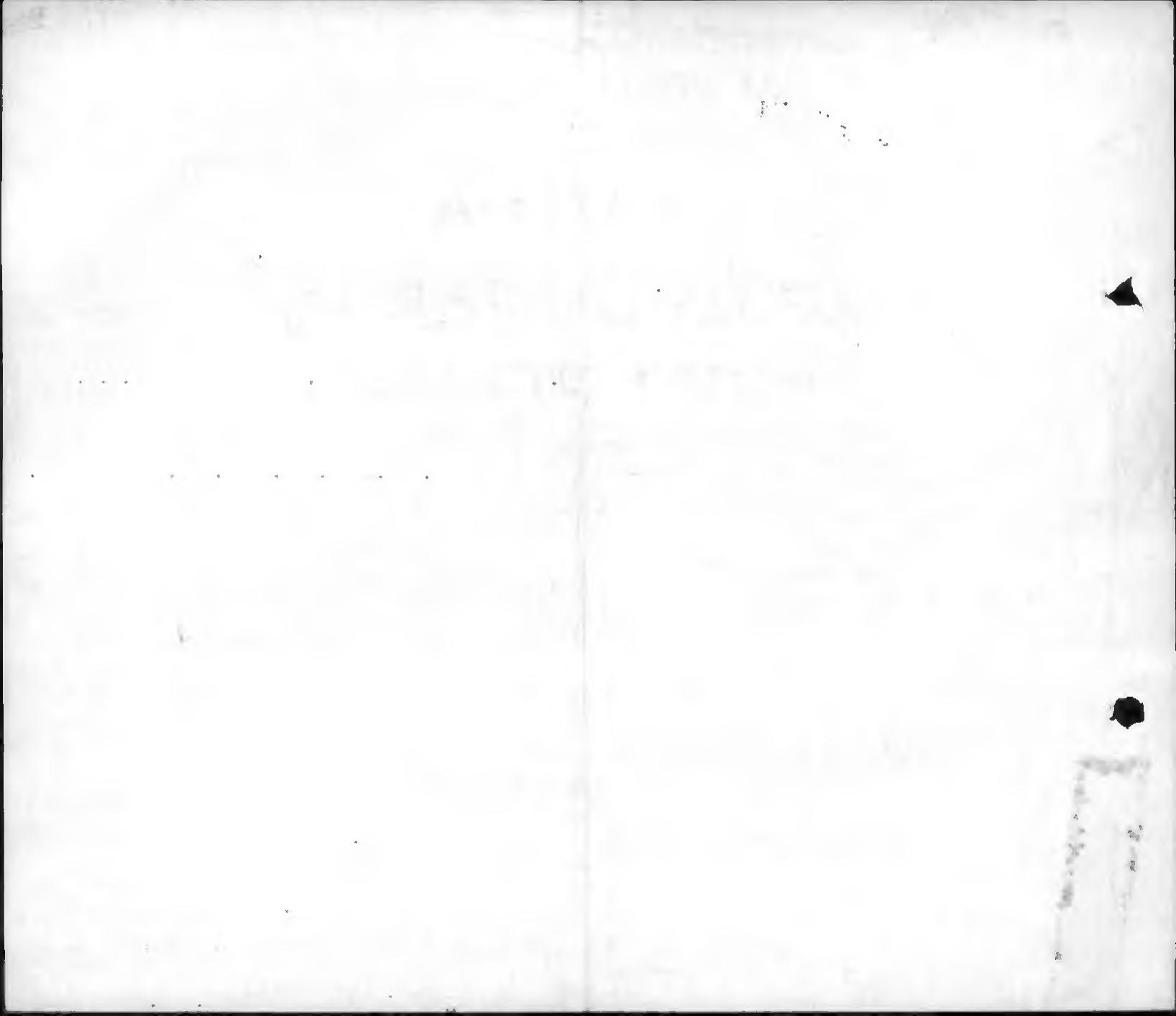
01362

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1403 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Baltimore		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural give location) 1800 Etting Street	
3. NAME OF DECEASED: (Type or Print) WILLIAM B. ALLEN		4. DATE (Month) (Day) (Year) OF DEATH, February 4, 1956	
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed	8. DATE OF BIRTH: 12/11/01
9. AGE last birthday 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY: Trucking Co.	
11. BIRTHPLACE (State or foreign country): Millwood, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: William Allen		14. MOTHER'S MAIDEN NAME: Laura Bray	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes WW I		16. SOCIAL SECURITY NO. 215-12-8855	
17. INFORMANT & ADDRESS: Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
581.1 IMMEDIATE CAUSE (A) HEPATIC COMA DUE TO			
ANTECEDENT CAUSE (B) LAENNEC'S CIRRHOSIS DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
UNKNOWN			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 12, 1956, to Feb. 4, 1956, that I last saw the deceased <del>XXXXXX</del> and that death occurred at 9:40 A.M. from the causes and on the date stated above. SIGNATURE JOHN A. SUMMERTON ADDRESS DATE SIGNED 2/4/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2/8/56 NAME OF CEMETERY OR CREMATORIAL Baltimore National Cemetery	
LOCATION (City, town, or county) Baltimore, Maryland			
DATE REC'D BY LOCAL REGISTRAR Feb 8, 1956		24. FUNERAL DIRECTOR ADDRESS Charles R. Lay Funeral Home, Baltimore, Maryland	
REGISTRAR'S SIGNATURE G. W. Hedrick			



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01363

## 1494 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN end give nearest town)	Baltimore MARYLAND	STATE Md.	COUNTY Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS Overlea	LENGTH OF STAY (In this place) 25 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 11 Cliftwood Rd	
3. NAME OF DECEASED (First) John (Middle) Wesley (Last) Amoss		4. DATE (Month) (Day) (Year) OF DEATH Feb. 4 1956	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 9-19-78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Huckster		10b. KIND OF BUSINESS OR INDUSTRY Produce	9. AGE last birthday 77 yrs.
13. FATHER'S NAME Unknown Amoss		14. MOTHER'S MAIDEN NAME Unknown Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 213 30 2468	17. INFORMANT & ADDRESS Daughter, 11 Cliftwood Rd
18. MEDICAL CERTIFICATION IMMEDIATE CAUSE (A) Cerebral thrombosis ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Cerebral arteriosclerosis GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (C)			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above. SIGNATURE Ronald Vardon M.D. 1077 Hayford Rd Baltimore, Md. 2-4-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Feb. 8, 1956	NAME OF CEMETERY OR CREMATORIAL Loudon Park	LOCATION (City, town, or county) (State) Balto, Md.
24. REC'D BY REGISTRAR FEB 9 1956	REGISTRAR'S SIGNATURE Mrs. D. L. Rutherford	25. FUNERAL DIRECTOR'S SIGNATURE Lansdale Funeral Home - 7401 Belair Rd.	

BUREAU V. S.

2001-07-03

RECEIVED

01364

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

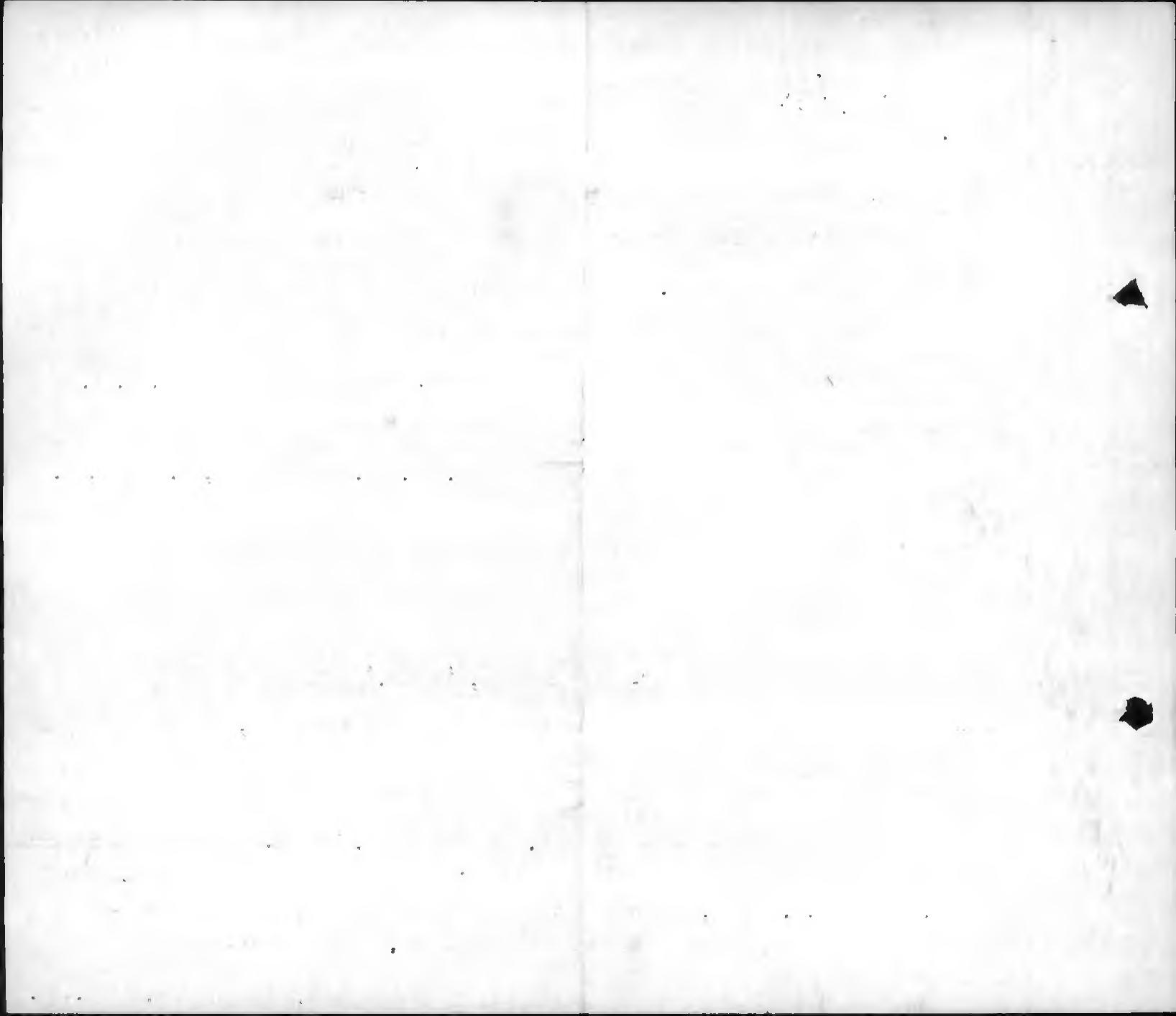
## 1495 CERTIFICATE OF DEATH

Reg. Dist. No. 44

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE MARYLAND		STATE MARYLAND COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN FORT HOWARD		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE	
3 Days		(If rural give location) STREET ADDRESS 206 NORTH CHAPEL STREET	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		3 YO1-4	
3. NAME OF DECEASED: (Type or Print) LEMUEL T. ANDERTON		4. DATE (Month) (Day) (Year) OF DEATH FEBRUARY 13 19 56	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED: (Specify) Married	8. DATE OF BIRTH: January 29, 1897
9. AGE last birthday yrs. 59	10. KIND OF BUSINESS OR INDUSTRY: Waterman	11. BIRTHPLACE (State or foreign country): Sanford, Virginia	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Lee Anderton	14. MOTHER'S MAIDEN NAME: Caroline Andrews		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT & ADDRESS: Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>355X</i>			
IMMEDIATE CAUSE (A) ACUTE BRAIN SYNDROME OF UNKNOWN CAUSE ANTECEDENT CAUSE (B) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATHS <i>(1) Tenosynovitis, acute, right second finger. (2) Bronchitis, chronic. (3) Bronchial asthma</i>			
19A. DATE OF OPERATION: 2-10-56	19B. MAJOR FINDINGS OF OPERATION Incision and drainage of tenosynovitis and felon, right		
20A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb. 10, 1956, to Feb. 13, 1956, <i>VA</i> and that death occurred at 7:35 A.M. from the causes and on the date stated above. SIGNATURE <i>Joseph M. Miller</i> ADDRESS DATE SIGNED <i>2-13-56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Feb. 16/56	NAME OF CEMETERY OR CREMATORIAL Baltimore National Cem.	LOCATION (City, town, or county) (State) Baltimore, Maryland
DATE REC'D BY LOCAL REGISTRAR <i>14-16-56</i>	REGISTRAR'S SIGNATURE <i>J. W. Hedrick</i>	24. FUNERAL DIRECTOR	ADDRESS Philip Herwig Sons, 2024 Orleans, Balto., Md.



**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS. ASC 145-10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01365

## 1406 CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY Maryland Baltimore Hereford (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS York Rd.		STREET ADDRESS York Rd.	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) Febr. 23 (Day) 1956 (Year)	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Jan. 6, 1888
9. AGE last birthday 68 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shuttle Operator	11. KIND OF BUSINESS OR INDUSTRY Construction	12. BIRTHPLACE (State or foreign country) Parkton, Md. R.D. 2 U. S. A.
13. FATHER'S NAME Joshua Armacost	14. MOTHER'S MAIDEN NAME Lida Miller	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, unk.) No	
16. SOCIAL SECURITY NO. 23-28-1752		17. INFORMANT & ADDRESS Mrs. Grace Armacost, Monkton, Md.	
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) Arterio Sclerosis Cerebrale ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 3 years			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from... <u>Jan. 22, 1956</u> , to <u>Feb. 23, 1956</u> , that I last saw the deceased alive on <u>Jan. 22, 1956</u> , and that death occurred at <u>6:35 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Whitney B. Tracy</u> ADDRESS (Street, city, town, state) <u>White Hall 3rd</u> DATE SIGNED <u>Feb. 25, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 26, 1956	
24. REC'D BY REGISTRAR DATE <u>Feb. 26, 1956</u>		NAME OF CEMETERY OR CREMATORIUM Fosters Cemetery	
		LOCATION (City, town, or county) Hereford, Monkton, Md. R.D.	
		REGISTRAR'S SIGNATURE Robert J. Fenton	
		25. FUNERAL DIRECTOR'S SIGNATURE Jacob Hartenstein, New Friends	

8. A. 1111111111

1. 2. 3. 4.

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 7/1/56

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01366

## 1497 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> CITY [If outside corporate limits, write RURAL OR and give nearest town] TOWN <u>TOWNSON</u>		MARYLAND LENGTH OF STAY (In this place)		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u> CITY [If outside corporate limits, write RURAL and give nearest town] TOWN <u>TOWNSON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7906 KNOLLWOOD RD.</u>		STREET ADDRESS <u>7906 KNOLLWOOD RD.</u>		(If rural give location)	
3. NAME OF DECEASED (First) <u>GEORGE</u> (Middle) <u>ANDREW</u> (Last) <u>BAETZ</u> (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH <u>2-9-1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>1-27-1889</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months <u></u> Dey <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER AT BUDGS. BALTO. MD.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>HELEN M. BAETZ - SAME</u>	
13. FATHER'S NAME <u>JOHN BAETZ</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET STECKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-05-0139</u>		17. INFORMANT & ADDRESS <u>HELEN M. BAETZ - SAME</u>	
18. MEDICAL CERTIFICATION <u>Carcinomatosis Ca. of Colon</u>					
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>Ca. of Colon</u>					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
19a. DATE OF OPERATION <u>1/21/56</u>		19b. MAJOR FINDINGS OF OPERATION <u>Advanced Ca. of Colon</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) <u>BALTIMORE</u> (State) <u>MARYLAND</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		21c. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>M. at work</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>November 19, 1955</u> to <u>2/9/1956</u> , that I last saw the deceased alive on <u>2/9/1956</u> , and that death occurred at <u>7:05 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>John Dunn, M.D.</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2/13/56</u>		NAME OF CEMETERY OR CREMATORIAL <u>SACRED HEART JESUS</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mabel Grays</u>		LOCATION (City, town, or county) <u>BALTIMORE CO. MD.</u> (State) <u>MARYLAND</u>	
DATE <u>2/13/56</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry M. Jenkins Jr.</u>	
				ADDRESS <u>44905 York Rd.</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1801367

1498

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

## 1. PLACE OF DEATH

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)LENGTH OF STAY  
(in this place)

TOWN Owings Mills

4 yrs. 10 mos.

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

12 Rosewood St. Tr. School

3. NAME OF  
DECEASED  
(Type or Print)

(First)

(Middle)

(Last)

Linda

Jean

Baird

5. SEX: 6. COLOR OR  
RACE:7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify)

8. DATE OF BIRTH

female

white

single

2/21/49

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life.  
even if retired):10B. KIND OF BUSINESS  
OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT  
COUNTRY?

13. FATHER'S NAME:

William Lloyd Baird

IS WAS DECEASED EVER IN U.S. ARMED FORCES  
(Yes, no, or unk.) If Yes, give war or dates  
of service)

16. SOCIAL SECURITY NO.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## IMMEDIATE CAUSE

(A)

DUE TO

Bilateral interstitial pneumonia

INTERVAL BETWEEN  
ONSET AND DEATH

Seven days

## ANTECEDENT CAUSE (B)

(B)

DUE TO

Repeated aspiration of food.

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE

DISEASE OR CONDITION CAUSING DEATH.

Brain scars + internal hydrocephalus due to col-

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

Tubercular meningitis

20. AUTOPSY?

YES  NO 21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
While  Not while   
at work  at work 

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from , 19 , to , 19 , that I last saw the deceased

alive on 2/22 , 1956, and that death occurred at 6:15 p.m. from the causes and on the date stated above.

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)

Edgehill Cemt

West Nanticoke, Pa

DATE REC'D BY LOCAL  
REGISTRAR

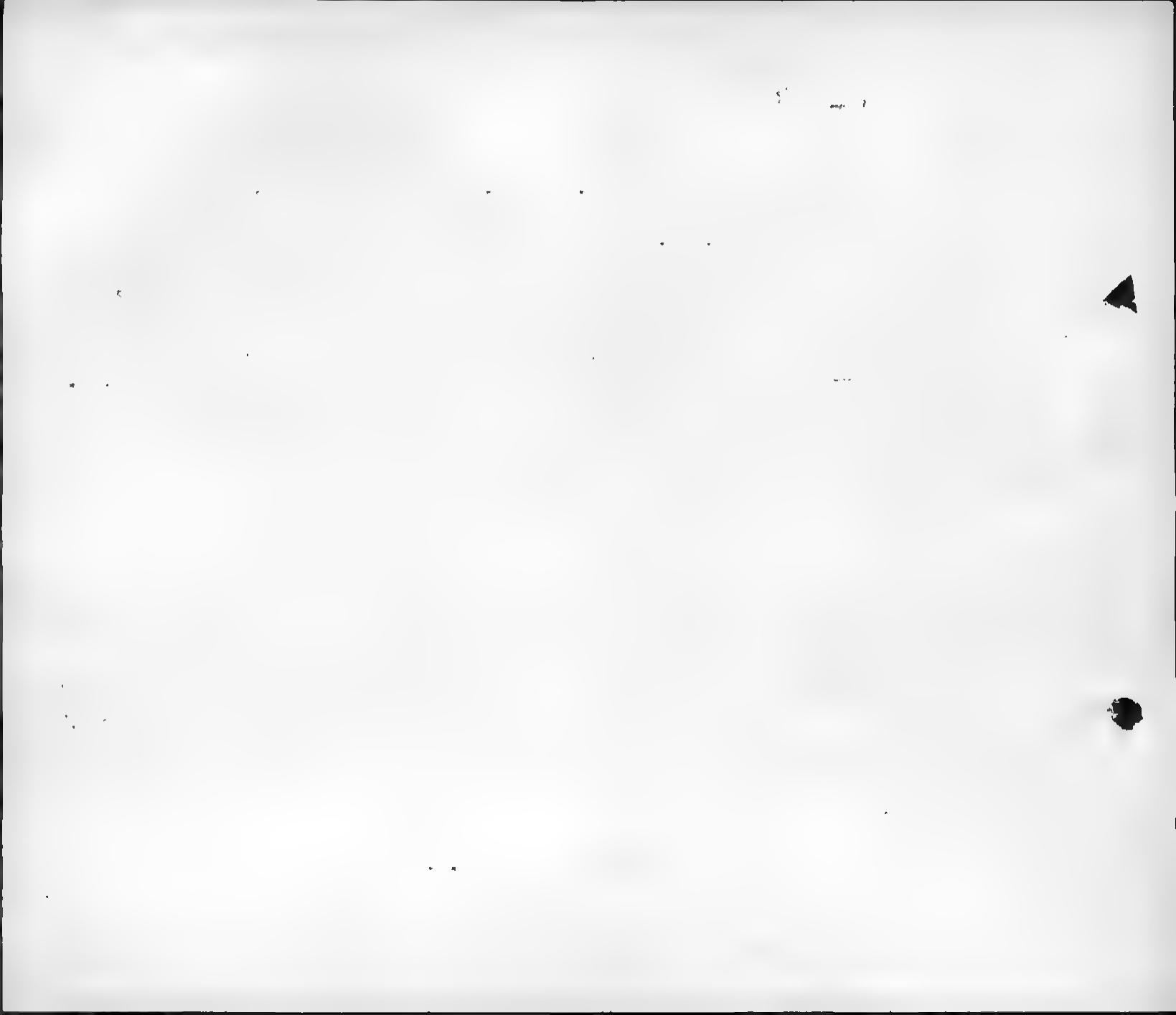
REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

2-24-56

W. J. Jackson &amp; Sons, Baltimore, Md.



**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

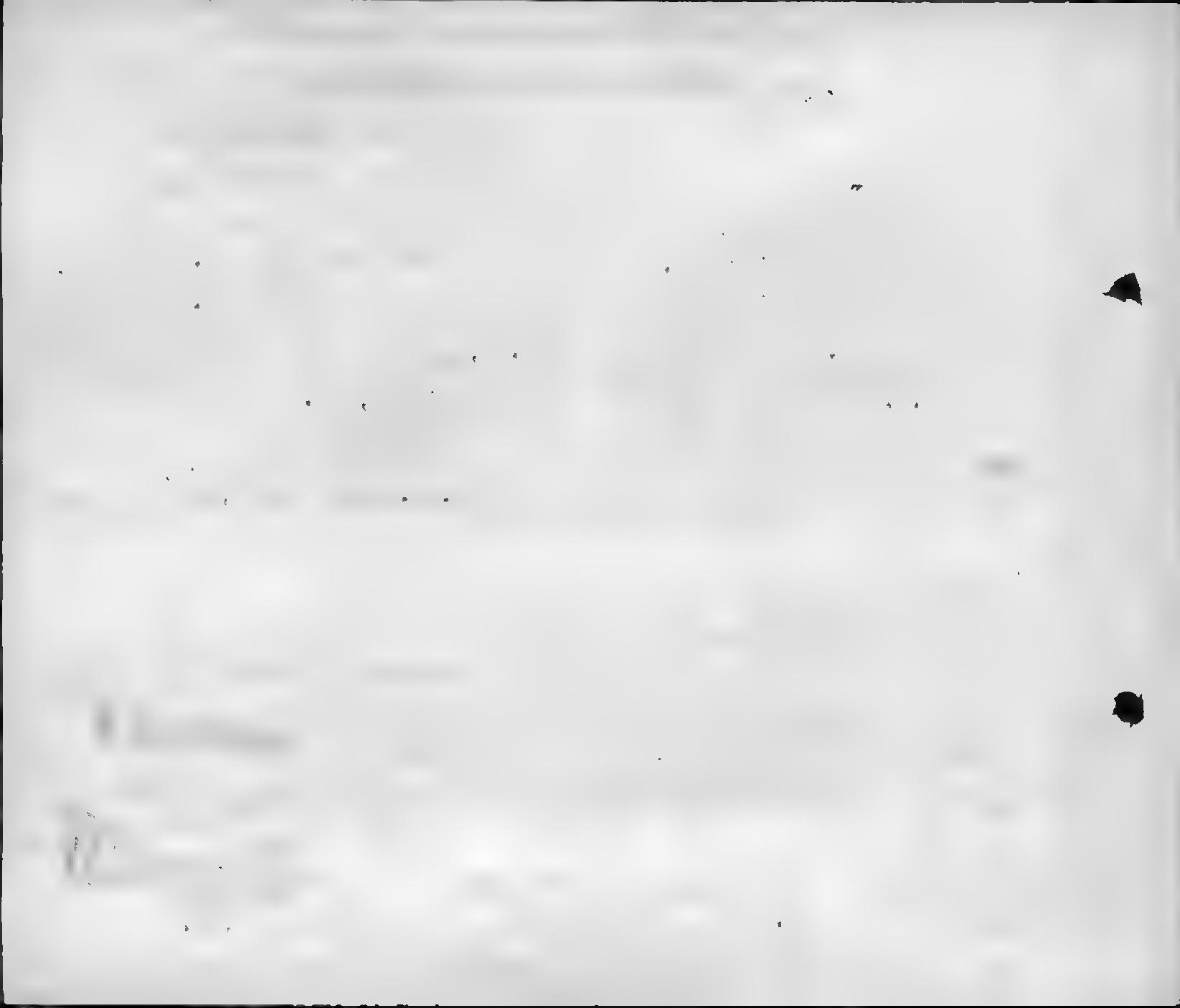
1479

**CERTIFICATE OF DEATH**

01368

Reg. Dist. No. 3

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <b>Baltimore</b>	MARYLAND	STATE <b>Md.</b>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Catonsville</b>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>House in Pines 16 Fusting Ave.</b>	STREET ADDRESS	(If rural give location) <b>5005 Woodside Rd.</b>	
<b>3. NAME OF DECEASED (Type or Print)</b> <b>Fannie Beaumont</b>		<b>4. DATE OF DEATH</b> <b>Feb. 6/56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Sept. 4, 1872</b>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	9. AGE last birthday <b>83</b> yrs.
13. FATHER'S NAME <b>John William Buckingham</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	12. CITIZEN OF WHAT COUNTRY?
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS (Daughter) <b>Mrs. J. Fred Graves, 5005 Woodside Rd.</b>	
<b>18. MEDICAL CERTIFICATION</b>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>Myocardial Decomposition</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Chronic Cardio-Vascular Disease</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>9-11-56</b> , 19 <b>49</b> , to <b>2-6</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>2-5</b> , 19 <b>56</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.			
SIGNATURE <b>Malvina F. Gallager</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Feb. 9/56</b>	NAME OF CEMETERY OR CREMATORIUM <b>Doudon Park</b>
24. REC'D BY REGISTRAR <b>DATE</b> <b>FEB 8 1956</b>		REGISTRAR'S SIGNATURE <b>F. E. Harry</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Harry H. Witke</b>
ADDRESS <b>4101 Edmondson AVE</b>			



*Medical Examiners Certificate*  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01369

1410

CERTIFICATE OF DEATH

Reg. Dist. No. 43

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN Raspeburg

LENGTH OF STAY  
(in this place)

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

7936 Oakdale Avenue

3. NAME OF  
DECEASED.  
(Type or Print)

(First) MARY L. BECKER

(Middle)

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md.

COUNTY Baltimore

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Raspeburg

(If rural give location)

7936 Oakdale Avenue

4. SEX:

Female

6. COLOR OR  
RACE:

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify):

single

8. DATE OF BIRTH:

Feb. 22, 1898

9. AGE last birthday

58 yrs.

IF UNDER 1 YEAR  
Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired):

Housework

10B. KIND OF BUSINESS  
OR INDUSTRY:

At Home

11. BIRTHPLACE (State or foreign country):

Baltimore, Md.

12. CITIZEN OF WHAT  
COUNTRY?

USA

13. FATHER'S NAME:

Henry Becker

14. MOTHER'S MAIDEN NAME:

M. W. Gramder

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates  
of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT & ADDRESS

Mr. Henry Becker, 7936 Oakdale Ave., Balto. 6

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

(A) IMMEDIATE CAUSE

DUE TO

*Pulmonary Embolus*

INTERVAL BETWEEN  
ONSET AND DEATH

1 hour

ANTECEDENT CAUSE (S)

DUE TO

*Causes of heart*

2 yrs.

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES  NO

21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
While  Not while   
at work  at work

21F. HOW DID INJURY OCCUR?

*Inspected*

22. I hereby certify that I ~~examined~~ the deceased from 2-23-52 to 2-27-52, 1952, that I last saw the deceased

\*alive on 10/10/52, and that death occurred at 10/10/52, M., from the causes and on the date stated above.

SIGNATURE *Spelt Collins* ADDRESS *M.D.* DATE SIGNED *2-27-52*  
REMARKS *Dept Med Examiner 2nd Flr 2218 Balt 2-27-52*

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)  
burial

DATE THEREOF  
2/25/56

NAME OF CEMETERY OR CREMATORIUM  
St. Pauls Cemetery

LOCATION (City, town, or county)  
Baltimore, Maryland (State)

DATE REC'D. BY LOCAL  
REGISTRAR

REGISTRAR'S SIGNATURE

*Feb. 24 '56 Mrs. M. D. Reznikoff, deceased, House 7401 Belair Rd.*

DUKEAU V. S.

FEB 29 1922

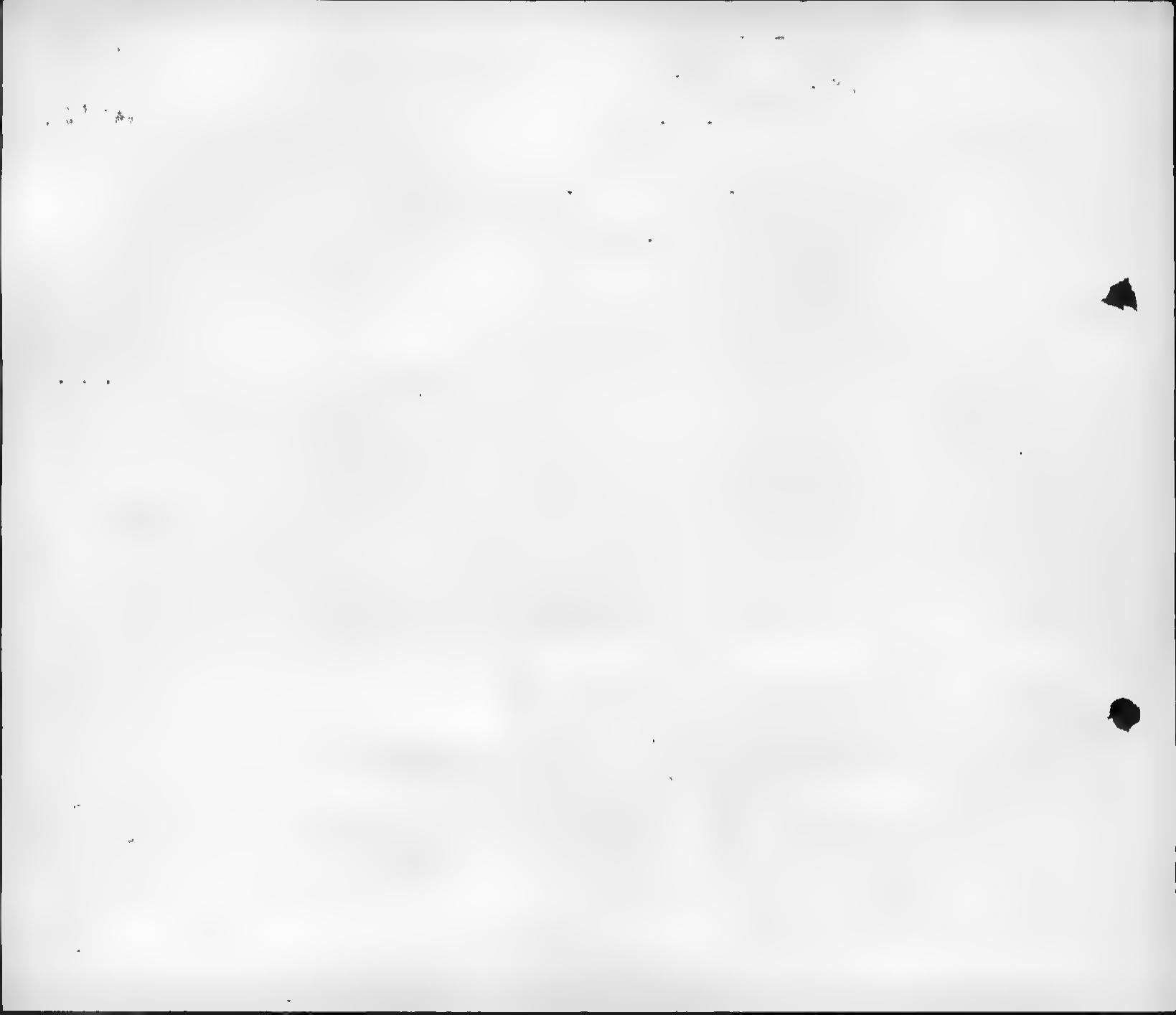
REGELIVE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01370

## 1411 CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH <u>Rosewood St. Tr. School</u>		2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>City</u>		
CITY (If outside corporate limits, write RURAL OR and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Owings Mills, Md.</u>		LENGTH OF STAY (in this place)	TOWN <u>Baltimore 15, Maryland</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS			
<u>Rosewood State Tr. School</u>		<u>4505 Post Road</u>			
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year)			
<u>Frederick PETER Behm</u>		OF DEATH <u>2/29/1956</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>			
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>single</u>		8. DATE OF BIRTH: <u>11/1/13</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		9. AGE last birthday <u>42</u> IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Mins <u>0</u>			
10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>			
13. FATHER'S NAME: <u>Peter George Behm</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT & ADDRESS: <u>Rosewood Records</u>		18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>49</u>		INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE <u>Pulmonary Edema</u>		(A) DUE TO			
ANTECEDENT CAUSE (B) <u>Bilateral Pneumonia</u>		DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Mongoloid, idiot</u>		(C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION: <u>19B. MAJOR FINDINGS OF OPERATION</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) <u>OF INJURY</u>		21C. WHERE DID INJURY OCCUR? (City or town) <u>(County)</u> <u>(State)</u>	
21D. TIME (Month) (Day) (Year) (Hour) <u>OF INJURY</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>9/1</u> , 19 <u>54</u> to <u>2/29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/29</u> , 19 <u>56</u> , and that death occurred at <u>11:00aM</u> , from the causes and on the date stated above. SIGNATURE <u>Carl S. Bander</u> ADDRESS <u>2920 N. CALVERT ST. 2-29-56</u> DATE SIGNED <u>2-29-56</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>MARCH 2, 1956</u>		NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) <u>LOUDON PARK CEM.</u> <u>BALTIMORE MD.</u> (State)	
DATE REC'D BY LOCAL REGISTRAR <u>3-56</u>		REGISTRAR'S SIGNATURE <u>W. H. Bander</u>		24. FUNERAL DIRECTOR & SONS, INC. ADDRESS <u>HENRY BANDER &amp; SONS, INC.</u> <u>BALTIMORE MD.</u> <u>Henry Bander</u>	







## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC-55 10A

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01372

## 1413 CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	Baltimore	MARYLAND	STATE
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Reisterstown	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Cockeysmill Road		STREET ADDRESS
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
Charles	F.	Bertsch	4. DATE OF DEATH
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH
Male	White		May, 26, 1877
9. AGE last birthday yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. (Year)
78			1956
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Farmer Self Employed			Germany
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Jacob Bertsch		Sophie Hagar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
(If Yes, give war or dates of service) No		none	Mr. Charles P. Bertsch, Reisterst
18. MEDICAL CERTIFICATION			
<p>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>IMMEDIATE CAUSE (A) <u>coronary thrombosis</u>            ANTECEDENT CAUSE(S) DUE TO <u>sudden</u>            DISEASES OR CONDITIONS, IF ANY, (B) <u>hypertension &amp; general</u>            GIVING RISE TO THE ABOVE CAUSE, DUE TO <u>arteriosclerosis</u>            STATING UNDERLYING CAUSE LAST. DUE TO <u>Diabetes mellitus</u>            (C)</p> <p>INTERVAL BETWEEN ONSET AND DEATH <u>no years</u></p>			
<p>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</p>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>1-1-1956</u> , to <u>2-10-1956</u> , that I last saw the deceased alive on <u>1-1-1956</u> , and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>James J. Eline</u> ADDRESS (Street, city, town, state) <u>Reisterstown Md.</u> DATE SIGNED <u>2-11-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 13, 1956	NAME OF CEMETERY OR CREMATORI Lorraine Cemetery
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Mary B. Eline	25. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Son's Reisterstown, Md.
DATE 2-12-56		ADDRESS	

BUREAU V. S

FEB 15 1968

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

The bottom copy may be retained by the hospital or attending physician.

VS AUSC 155 10A

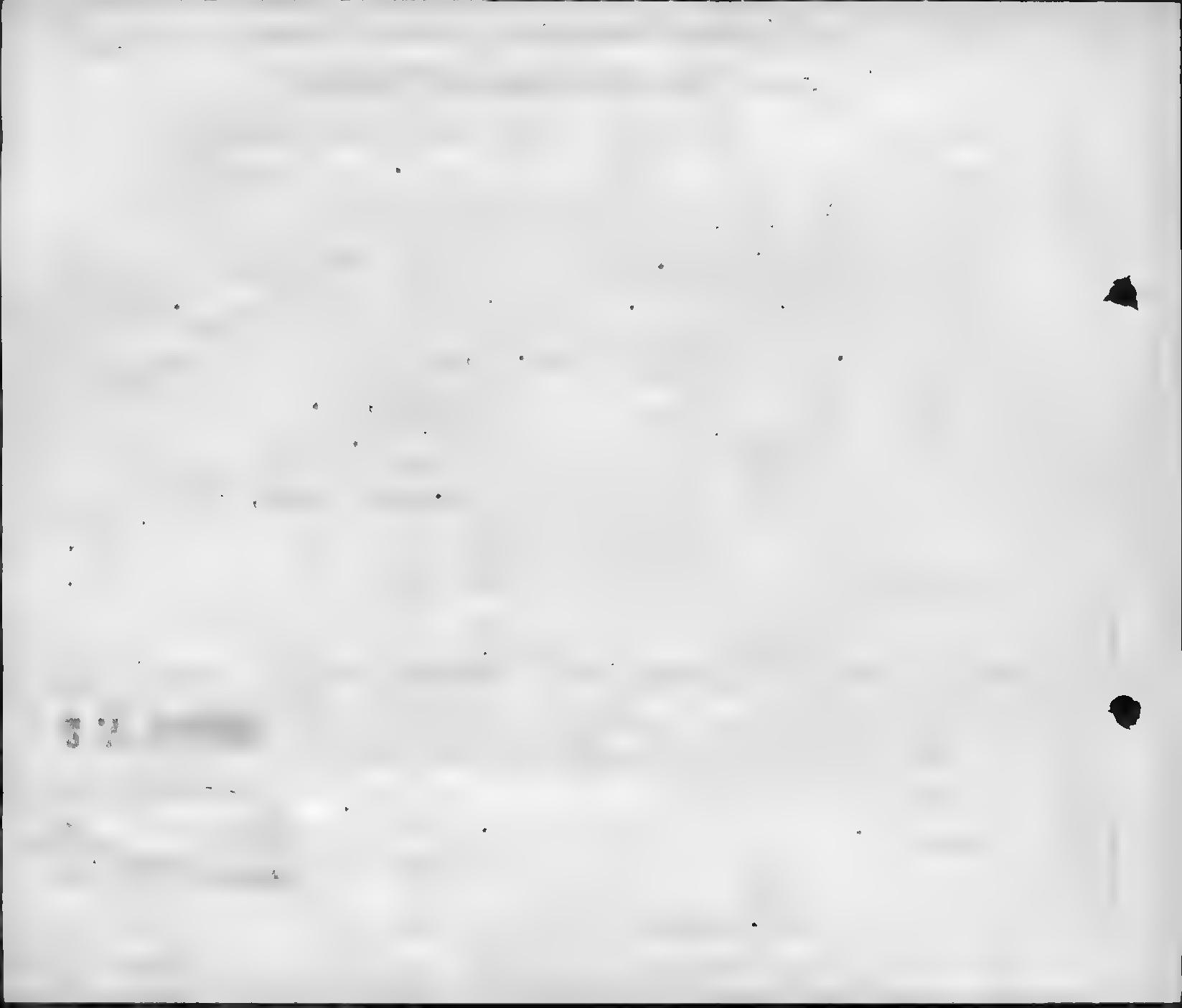
## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01373

## 1414 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>Baltimore</b> CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Catonsville</b>		MARYLAND LENGTH OF STAY (In this place) STATE <b>Md.</b> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore</b> STREET ADDRESS <b>524 Edgewood St</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>House in Pines</b> <b>15 Rusting Ave.</b>		(If rural give location) <b>524 Edgewood St</b>	
3. NAME OF (First) <b>Caroline</b> (Middle) <b>M. Biemiller</b> (Type or Print)		4. DATE (Month) (Day) (Year) <b>Feb. 6/56 19</b>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Female	W.	Single	<b>Aug. 21, 1868</b>
9. AGE last birthday	10. IF UNDER 1 YEAR Months <b>87</b> yrs.		11. IF UNDER 24 HRS. Hours <b>87</b> Min.
<b>87</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Henry Biemiller</b>		14. MOTHER'S MAIDEN NAME <b>Caroline M. Preisz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS <b>Mrs. Caleb Dorsey, 3513 Edmondson</b>	
18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <b>Coronary occlusion</b> ANTECEDENT CAUSE(S) DUE TO (B) <b>Cardio vascular disease</b> DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) (C)			
INTERVAL BETWEEN ONSET AND DEATH <b>2 min.</b>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Arterio sclerosis</b>			
? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) <b>White</b>		(County) <b>Edmondson</b> (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>4.30 P.M.</b>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>May 19, 52</b> , to <b>Feb. 6, 1956</b> , that I last saw the deceased alive on <b>Dec. 30, 1955</b> , and that death occurred at <b>4.30 P.M.</b> from the causes and on the date stated above. SIGNATURE <b>Walter O'Kieff</b> M.D. <b>2220 Garrison Blvd.</b> DATE SIGNED <b>2/1/56</b> ADDRESS <b>Edmondson Blk. Balto. Md.</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Feb. 9/56</b>	
24. REC'D. BY REGISTRAR <b>Feb. 10/56</b>		NAME OF CEMETERY OR CREMATORIAL <b>Edmondson Blk. Balto. Md.</b>	
DATE		LOCATION (City, town, or county) (State)	
REGISTRAR'S SIGNATURE <b>T. E. Barry</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Harry A. W. 4101 Edmondson</b>	
ADDRESS		ADDRESS	



1415

## CERTIFICATE OF DEATH

Reg. Dist. No. . . .

1. PLACE OF DEATH: COUNTY <u>Calonsville</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>03X-1</u>	
CITY (If outside corporate limits, write RURAL OR TOWN <u>Baltimore</u> ) LENGTH OF STAY (in this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> STREET ADDRESS <u>W. House of Correction, Redwood, Md.</u>	
3. NAME OF DECEASED: (Type or Print) <u>Joseph</u>		(Last) <u>Blitzman</u>	
4. SEX: <u>M</u>	5. COLOR OR RACE: <u>W.</u>	6. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Single</u>	7. DATE OF BIRTH: <u>5 - 24 - 1898</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>-</u>	
13. FATHER'S NAME: <u>Michael</u>		14. MOTHER'S MAIDEN NAME: <u>Rebecca</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>unkn</u> (If Yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT & ADDRESS: <u>Records Spring State Hlth Hosp.</u>		18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE <u>Cardio-vascular disease</u> ANTECEDENT CAUSE (S) <u>(Central hemorrhage?)</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		19A. DATE OF OPERATION: <u>19B. MAJOR FINDINGS OF OPERATION</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		19C. WHERE DID INJURY OCCUR? (City or town) <u>Spring Grove State Hosp.</u> (County) <u>Calonsville</u> (State) <u>Md.</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) <u>Spring Grove State Hosp.</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>Dec. 7, 1953</u> , to <u>Feb. 16, 1956</u> , that I last saw the deceased alive on <u>Feb. 16, 1956</u> , and that death occurred at <u>6:50 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>J. Elyse Williams</u> ADDRESS <u>M. D. Spring Grove State Hosp.</u> DATE SIGNED <u>2-16-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Embalmed</u>		DATE THEREOF <u>2/21/56</u> NAME OF CEMETERY OR CREMATORIAL <u>un. of Med. Sch.</u> LOCATION (City, town, or county) <u>Baltimore, Md.</u> (State) <u>Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-3-6-1956</u>		REGISTRAR'S SIGNATURE <u>J. E. Harvey</u>	
24. FUNERAL DIRECTOR		ADDRESS	

## 3. A. *W. W. Mayo*

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15SC-155 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01375

## 1416 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY TOWN	Baltimore [If outside corporate limits, write RURAL OR and give nearest town] Fort Howard	MARYLAND LENGTH OF STAY [In this place] 10 Days	STATE Maryland CITY [If outside corporate limits, write RURAL and give nearest town] OR TOWN New Windsor STREET ADDRESS [If rural give location]
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) WILLIAM P.		(Month) (Day) (Year) February 13 1956	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH September 5, 1894
9. AGE last birthday 61 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter	10b. KIND OF BUSINESS OR INDUSTRY Buildings	11. BIRTHPLACE (State or foreign country) New Windsor, Maryland
12. CITIZEN OF WHAT COUNTRY U. S. A.	13. FATHER'S NAME Adam Bloom		
14. MOTHER'S MAIDEN NAME Mary Azealea	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WW I		
16. SOCIAL SECURITY NO. Unknown			17. INFORMANT & ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE RESIDUAL CARCINOMA OF LARYNX WITH METASTASIS ANTECEDENT CAUSE(S) TO LEFT BRACHIAL PLEXUS AND THE CERVICAL VERTEBRAE DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH Since 1952	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION 6-16-52		19b. MAJOR FINDINGS OF OPERATION Laryngectomy - Squamous Carcinoma found	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from Feb. 3, 1956, to Feb. 13, 1956, <del>and that death occurred at 5:00 P.M.</del> and that death occurred at 5:00 P.M. from the causes and on the date stated above SIGNATURE <i>Mark</i> DATE SIGNED 2-14-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2-15-56	NAME OF CEMETERY OR CREMATORIUM Presbyterian Cemetery
24. REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Dawson L. Farley</i>	LOCATION (City, town, or county) New Windsor, Maryland
DATE Feb. 16, 1956		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Md. Wm. Cook-Blight, Inc. 6069 Harford Rd., Balto.	

2 JULY 1968

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## 1390 CERTIFICATE OF DEATH

Reg. Dist. No. 40

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN Violatville LENGTH OF STAY  
 (In this place) 10 yrs  
 HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS 3807 Coolidge Ave

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY Baltimore  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN Violatville STREET ADDRESS  
 (If rural give location) 3807 coolidge ave

3. NAME OF  
 DECEASED: (First) Albert (Middle)  (Last) Boffan  
 (Type or Print)

4. DATE (Month) (Day) (Year)  
 OF DEATH: Febr 6 1956

5. SEX Male 6. COLOR OR RACE white 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married 8. DATE OF BIRTH: Apr 29 1872 9. AGE last birthday 83 yrs. 0 months 0 days 0 hours 0 min.

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Taylor 10B KIND OF BUSINESS OR INDUSTRY: Retired

11 BIRTHPLACE (State or foreign country): Germany 12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Conrad Boffan

14. MOTHER'S MAIDEN NAME: Frances Langar

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk) no 16. SOCIAL SECURITY NO 220-05-3620

17. INFORMANT & ADDRESS Mrs Amelia Boffan 3807 Coolidge Ave

18. MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE acute coronary occlusion, sub  
 ANTECEDENT CAUSE (B) coronary arteriosclerosis 3 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(A) DUE TO acute coronary occlusion, sub  
 (B) DUE TO coronary arteriosclerosis 3 yrs  
 (C) DUE TO hypertension

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES  NO

21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While  Not while   
 M. at work  at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Febr 5, 1956 to Febr 6, 1956, that I last saw the deceased

alive on Febr 6, 1956, and that death occurred at 3:15 P.M. from the causes and on the date stated above.

SIGNATURE John Boffan ADDRESS 3807 Coolidge Ave DATE SIGNED 2/6/56

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial DATE THEREOF 2-4-56 NAME OF CEMETERY OR CREMATORIAL John LOCATION (City, town, or county) (State)

DATE REC'D. BY LOCAL REGISTRAR John Boffan

REGISTRAR'S SIGNATURE John Boffan

24. FUNERAL DIRECTOR John Boffan ADDRESS 44 Jettison 4107 Wilkes



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01377

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH. <i>Rosewood Training School</i>		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY <i>Baltimore</i> MARYLAND		STATE <i>Md</i> COUNTY <i>Baltimore</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <i>Owings Mills.</i>		TOWN <i>Gwynedd</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <i>5606 Park Ave</i>	
3. NAME OF DECEASED: (First) <i>Albert</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>Feb 25, 1956</i>	
(Middle) <i>Francis</i>		9. AGE last birthday IF UNDER 1 YEAR Months <i>36</i> Days <i>7</i> Hours <i>11</i> Min.	
(Last) <i>Bonifant</i>		10. BIRTHPLACE (State or foreign country): <i>Germany</i>	
5. SEX: <i>M.</i> COLOR OR RACE: <i>White</i>		11. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>Single</i>		8. DATE OF BIRTH <i>10/14/19</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY:	
13. FATHER'S NAME: <i>Thomas Bonifant</i>		14. MOTHER'S MAIDEN NAME <i>Eve L. Gittings Bonifant</i>	
IS WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) <i>No</i>		15. SOCIAL SECURITY NO. <i>151-06-0605</i>	
16. MEDICAL CERTIFICATION		17. INFORMANT & ADDRESS <i>Eve L. Gittings</i>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  <i>178X</i> IMMEDIATE CAUSE ANTECEDENT CAUSE <i>(S)</i> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		(A) DUE TO <i>Malignant tumor of chest.</i> COMPRESION OF TRACHEA AND HEART FAILURE DUE TO EXTENSIVE METASTASES OF SEMINOMA. (B) DUE TO (C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION. <i>11-7-55-</i>		19B. MAJOR FINDINGS OF OPERATION <i>Seminoma at testicle.</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.) <i>2920 N. Calvert St.</i>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>M.</i>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Nov 2, 1955</i> , to <i>Feb 25, 1956</i> , that I last saw the deceased alive on <i>2/25/1956</i> , and that death occurred at <i>9:00 P.M.</i> from the causes and on the date stated above. SIGNATURE <i>John Arnal</i>		ADDRESS <i>1 M.D. 2920 N. Calvert St.</i> DATE SIGNED <i>2/26/56</i>	
23. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify) <i>Burial</i>		NAME OF CEMETERY OR CREMATORIAL <i>Argyros</i>	
DATE REC'D BY LOCAL REGISTRAR <i>2-27-56</i>		LOCATION (City, town, or county) <i>Ridge Rd. 20-500</i>	
REGISTRAR'S SIGNATURE <i>Mary B. Eliza.</i>		24. FUNERAL DIRECTOR ADDRESS <i>2046 15th St.</i>	

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**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

**REMEMBER:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

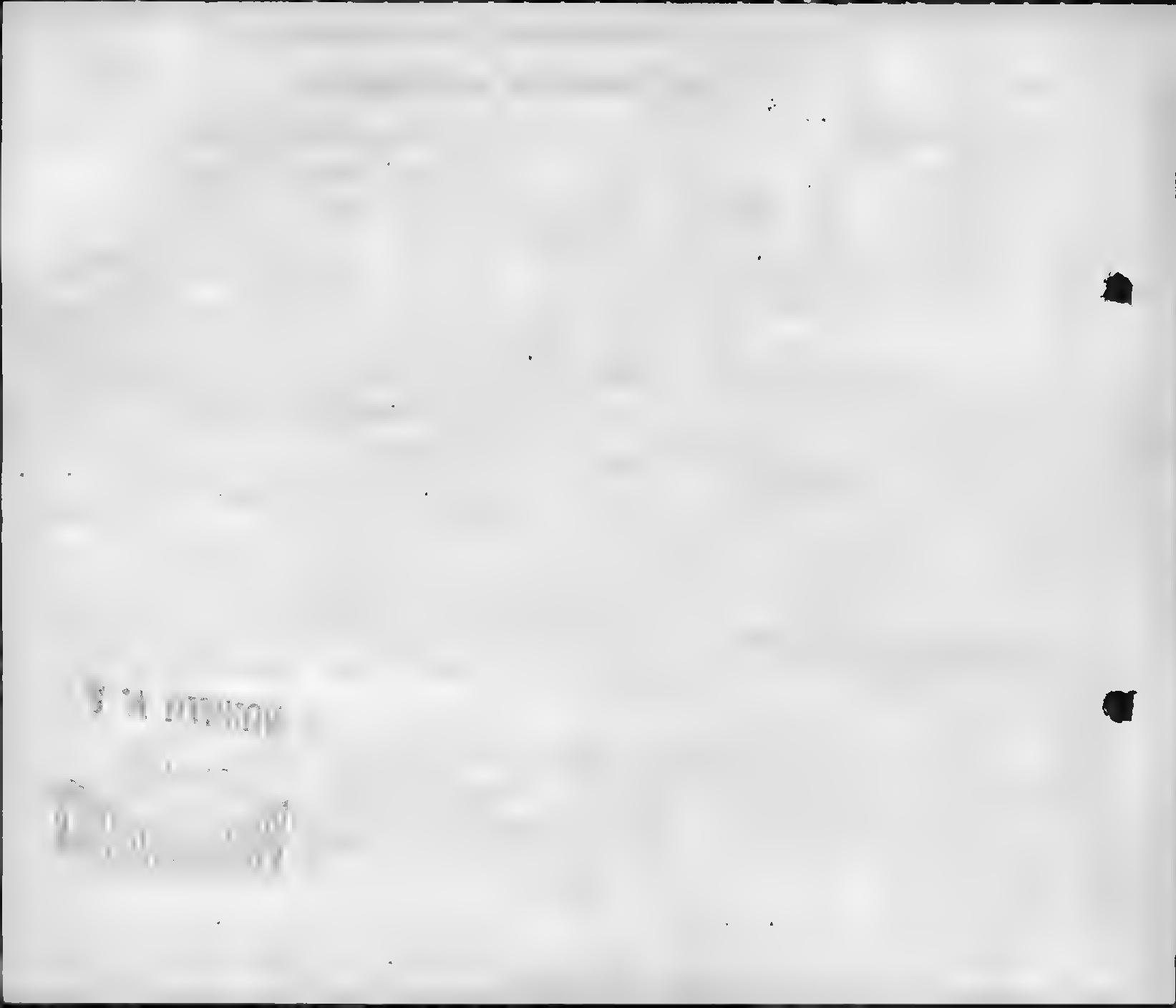
VS AISC 155-10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18****1418****CERTIFICATE OF DEATH**

Item 14, Film G193 2-23-56 et

**01378**Reg. Dist. No. **40**

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>					
COUNTY	Baltimore	MARYLAND	STATE	Maryland	COUNTY	Baltimore			
CITY (If outside corporate limits, write RURAL or TOWN and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)		STREET ADDRESS				
Kingsville			Kingsville		(If rural give location)				
HOSPITAL OR INSTITUTION OR STREET ADDRESS				Belair Rd. & Cherrol Road					
3. NAME OF DECEASED (First)		(Middle)	(Last)	4. DATE OF DEATH (Month)		(Day)	(Year)		
Elizabeth				Bo		se	Feb. 15 1956		
5. SEX	6. CO. OR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday		10. IF UNDER 1 YEAR			
F	W	widowed	Nov. 3, 1868	87	Yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
at home				Baltimore, Maryland		USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Kniesche				Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS		Kingsville, Md.			
(If Yes, give war or dates of service)				Mrs. Margaret Gonnen, Belair & Cherrol					
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>									
IMMEDIATE CAUSE (A)		ANTECEDENT CAUSE(S) DUE TO (B)		DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
				Coronary occlusion				45 min.	
				Generalized Arteriosclerosis				20 + yrs.	
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>									
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)					
(County)		(State)							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
M.									
<b>22. I hereby certify that I attended the deceased from Feb. 15, 1956, to Feb. 15, 1956, that I last saw the deceased alive on Feb. 15, 1956, and that death occurred at 10:45 A.M. from the causes and on the date stated above.</b>									
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED			
William A. Tyson				Kingsville, Md		Feb. 15, 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIUM		LOCATION (City, town, or county)			
Burial		Feb. 18, 1956		Parkwood Cemetery		Baltimore, Maryland			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS			
FEB 17 1956		Mrs. G. L. Ruppert		Leonard J. Ruck, 5305 Harford Road #14					
DATE		Dr. Walter Langford							



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 10W

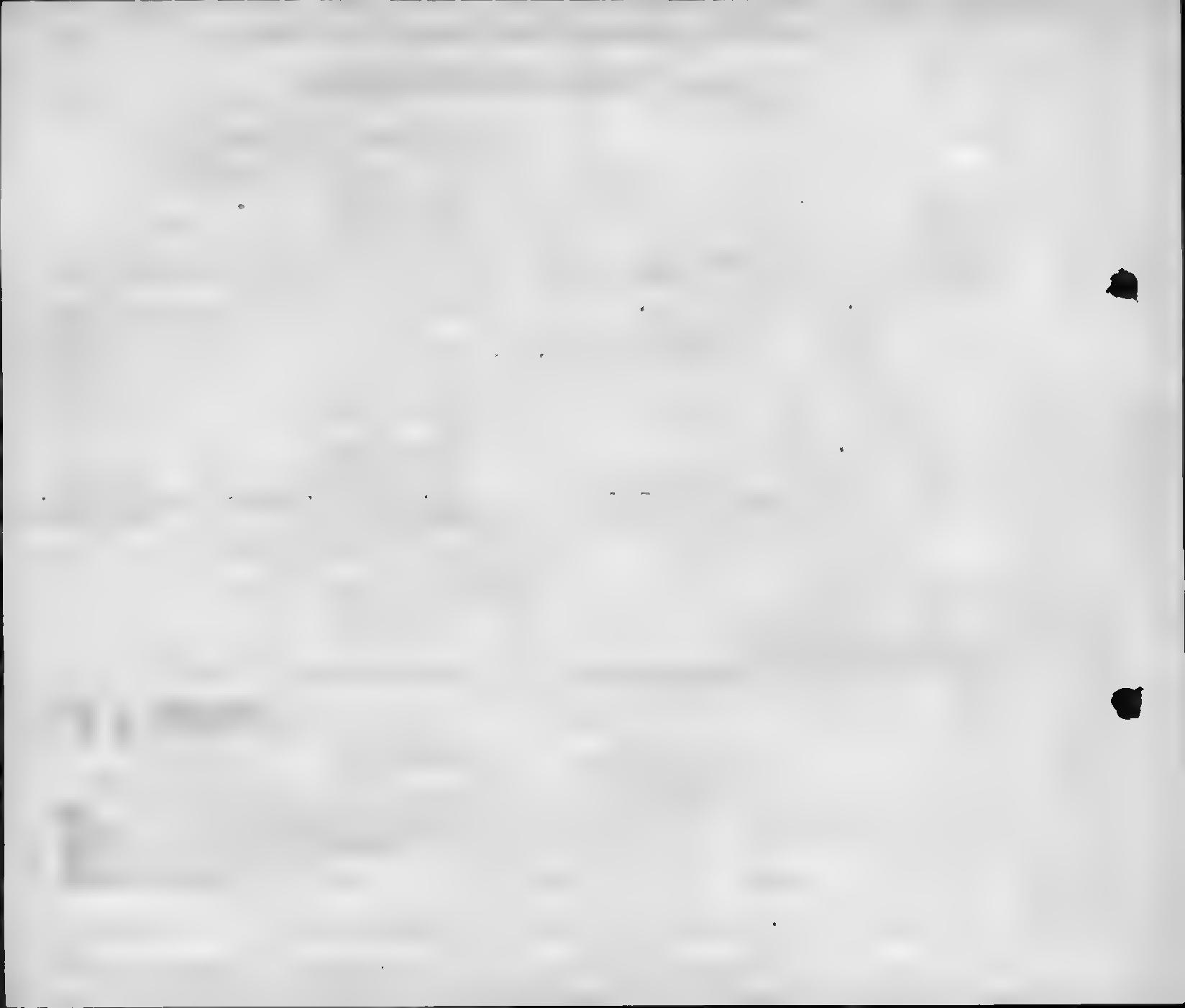
## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01379

## 1419 CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Baltimore Middle River	MARYLAND LENGTH OF STAY (in this place)	STATE Maryland COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Middle River STREET ADDRESS (If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) Mr. William C. Brandau		(Month) (Day) (Year) February 2nd 1956	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) widowed	8. DATE OF BIRTH Feb. 16, 1885
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
10c. FATHER'S NAME William O. Brandau		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. 215-22-5651	
17. INFORMANT & ADDRESS Mrs. Myrtle B. Young, A4 Kingston Rd.		14. MOTHER'S MAIDEN NAME Florence Rush	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		Coronary Occlusion Arterio - atherosclerotic cardiovascular disease	
(A) DUE TO (B) DUE TO (C) DUE TO		6 hours 5 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work at work	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb. 1956, to Feb. 2, 1956, that I last saw the deceased alive on Feb. 1, 1956, and that death occurred at 11 A.M. from the causes and on the date stated above.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF M.D. 1437 Fuselage Ave Baltimore, Maryland NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR FEB 6 1956 DATE		REGISTRAR'S SIGNATURE Mrs. Edith Shirley	
		25. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Harford Road #11 ADDRESS	



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01380

1420

## CERTIFICATE OF DEATH

Reg. Dist. No. 50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

## MARGIN RESERVED FOR FINDING

1. PLACE OF DEATH COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>MARYLAND</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Parkville</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Parkville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>3003 Action Rd</i>		STREET ADDRESS <i>3003 Action Rd</i>	
3. NAME OF DECEASED (Type or Print) <i>Susan</i>	(First) <i>Susan</i>	(Middle) <i>P</i>	(Last) <i>BRANDT</i>
4. DATE OF DEATH <i>Feb 19</i>	(Month) <i>Feb</i>	(Day) <i>19</i>	(Year) <i>1956</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLED, MARRIED, WIDOWED, DIVORCED; (Specify) <i>Divorced</i>	8. DATE OF BIRTH <i>JAN 17 1874</i>
9. AGE last birthday yrs. <i>82</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Press shop</i>	11. BIRTHPLACE (State or foreign country) <i>Penn.</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>
13. FATHER'S NAME <i>John</i>	14. MOTHER'S MAIDEN NAME <i>Susan</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>165-8-0000</i>	17. INFORMANT <i>Lenore C. Brandt</i>	18. MEDICAL CERTIFICATION <i>Gastritis of liver</i>	19. DATE OF OPERATION <i>1956</i>
20. AUTOPSY? <input type="checkbox"/> Yes <input type="checkbox"/> No		INTERVAL BETWEEN ONSET AND DEATH <i>6 mos</i>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>INJURY</i>	
22. TIME (Month) OF INJURY <i>Feb 18</i>	(Day) <i>1956</i>	(Hour) <i>6:50</i>	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> Not While <input type="checkbox"/>
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>Feb 23 1956</i>	NAME OF CEMETERY OR CREMATORIUM <i>Green Mount Cemetery</i>
DATE REC'D BY LOCAL REG. <i>2/20/56</i>	REGISTRAR'S SIGNATURE <i>G. M. Bacon</i>	LOCATION (City, town, or county) <i>York</i>	
24. FUNERAL DIRECTOR ADDRESS <i>Chas F. Evans &amp; Son 8802 Hartford Rd.</i>		(State) <i>Penn</i>	

BUREAU V. 2

FEB 9 1968

RECEIVED

01381

Reg. Dist.

1421  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 45

## 1. PLACE OF DEATH:

COUNTY

Balto

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
TOWNLENGTH OF STAY  
(in this place)HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESSMiddle River Waterfront  
Beach Drive

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md

COUNTY

Balto

CITY (If outside corporate limits write RURAL and give nearest town)  
OR  
TOWNSTREET  
ADDRESSMiddle River Waterfront  
Beach Drive zone 20.2. NAME OF  
DECEASED:  
(Type or Print)

August

(Middle)

(Last)

Bremer Jr

4. DATE  
OF  
DEATH

2

3

1956

## 5. SEX:

6. COLOR OR  
RACE7. SINGLE, MARRIED,  
WIDOWED, DIVORCED  
(Specify):

8. DATE OF BIRTH:

May 16 1912

9. AGE last birthday:

43

yrs

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
even if retired):10b. KIND OF BUSINESS OR  
INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT  
COUNTRY?

## 13. FATHER'S NAME:

August Bremer

## 14. MOTHER'S MAIDEN NAME:

Rebecca Lomack.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)

Yes

W.W.II

## 16. SOCIAL SECURITY NO.:

216-10-3199

## 17. INFORMANT &amp; ADDRESS:

See Bremer, 1534 Birkdale Rd.

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a).....

DUE TO

Cirrhosis, Cancer

INTERVAL BETWEEN  
ONSET AND DEATH

30 Min.

Antecedent cause(s)

(b).....

Diseases or conditions, if any, (b).....  
giving rise to the above cause DUE TO  
stating underlying cause last (c)II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes  No 21a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING    
CAUSE OF DEATH21b. PLACE (Home, farm, factory,  
OF street, office bldg., etc.,  
INJURY)

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)  
OF  
INJURY

M.

21e. INJURY OCCURRED  
While at Not while  
work  at work 

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

SIGNATURE

Jack K. Kellens

CHIEF MEDICAL EXAMINER  
DEPUTY MEDICAL EXAMINER  
M. D. ASSISTANT MEDICAL EXAM.

DATE SIGNED

23. BURIAL, CREMATION,  
REMOVAL (Specify):

Buy a

DATE THEREOF

REG. 2/9/6

NAME OF CEMETERY OR CREMATORIUM

Park Lawn Cen

LOCATION (City, town, or county)

Balto Md

(State)

Baltimore Funeral Home 7401 Barks Rd

DATE REC'D. BY LOCAL  
REG. 2/9/6

REGISTRAR'S SIGNATURE

Edith Shirley

24. FUNERAL DIRECTOR

ADDRESS



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1422

## CERTIFICATE OF DEATH

01382

Reg. Dist. No. ..

Item 8, FilmG193 3-6-56 et

## 1. PLACE OF DEATH.

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
OR and give nearest town) (in this place)TOWN CatonsvilleHOSPITAL OR  
INSTITUTION OR Home In the Pines.

STREET ADDRESS

16 Fulting Ave.

## 2. USUAL RESIDENCE (HOME) OF DECEASED.

STATE Maryland

COUNTY

Baltimore

CITY (If outside corporate limits, write RURAL and give nearest town)

OR

TOWN

Catonsville

STREET

ADDRESS

156 Sanford Road

## 3. NAME OF

DECEASED:

(Type or Print)

Joseph M. Brookhawn

(First)

(Middle)

(Last)

## 4. DATE

OF

DEATH

Feb:

25

19

67

(Year)

## 5. SEX:

6. COLOR OR

RACE:

(Specify)

7. SINGLE, MARRIED,

WIDOWED, DIVORCED,

(Specify)

INDUSTRY:

10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:

10b. KIND OF BUSINESS OR

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

Male White Married June 22 1866 89 USA

13. FATHER'S NAME:

James L. Brookhawn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.:

17. INFORMANT &amp; ADDRESS:

Mary Nagel Brookhawn

18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

DUE TO

LOP R. PNEUMONIA

Interval Between  
Onset And Death

6 days

Antecedent causes (s)

(b)

DUE TO

CEREBRAL APOLYX<sup>o</sup> LEFT HEMIPLEGIA - 2 MO

Diseases or conditions, if any, giving rise to the above cause

stating the underlying cause last.

(c)

DUE TO

SENSILITY AND APTEPIOSCLEROSIS.

Years

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

0

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

0

20. AUTOPSY ?

0

Yes  No 

## 21. ACCIDENT (Specify)

(a)

OF

INJURY

PLACE (Home, farm, factory, street,

or

office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)

INJURY OCCURRED

OF

While at

Not While

INJURY

m.

Work At Work 

HOW DID INJURY OCCUR?

DATE SIGNED

SIGNATURE (Degree or title)

ADDRESS

Lloyd Johnson M.D.

6348 Frederick Road Catonsville 2/27/56.

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county)

(State)

22. FUNERAL CREMATION, DATE THEREOF

REMOVAL (Specify)

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE

REGISTRAR

2/28/56

C. Young

2/28/56

H. B. Flippert

1700 E. 32nd Place

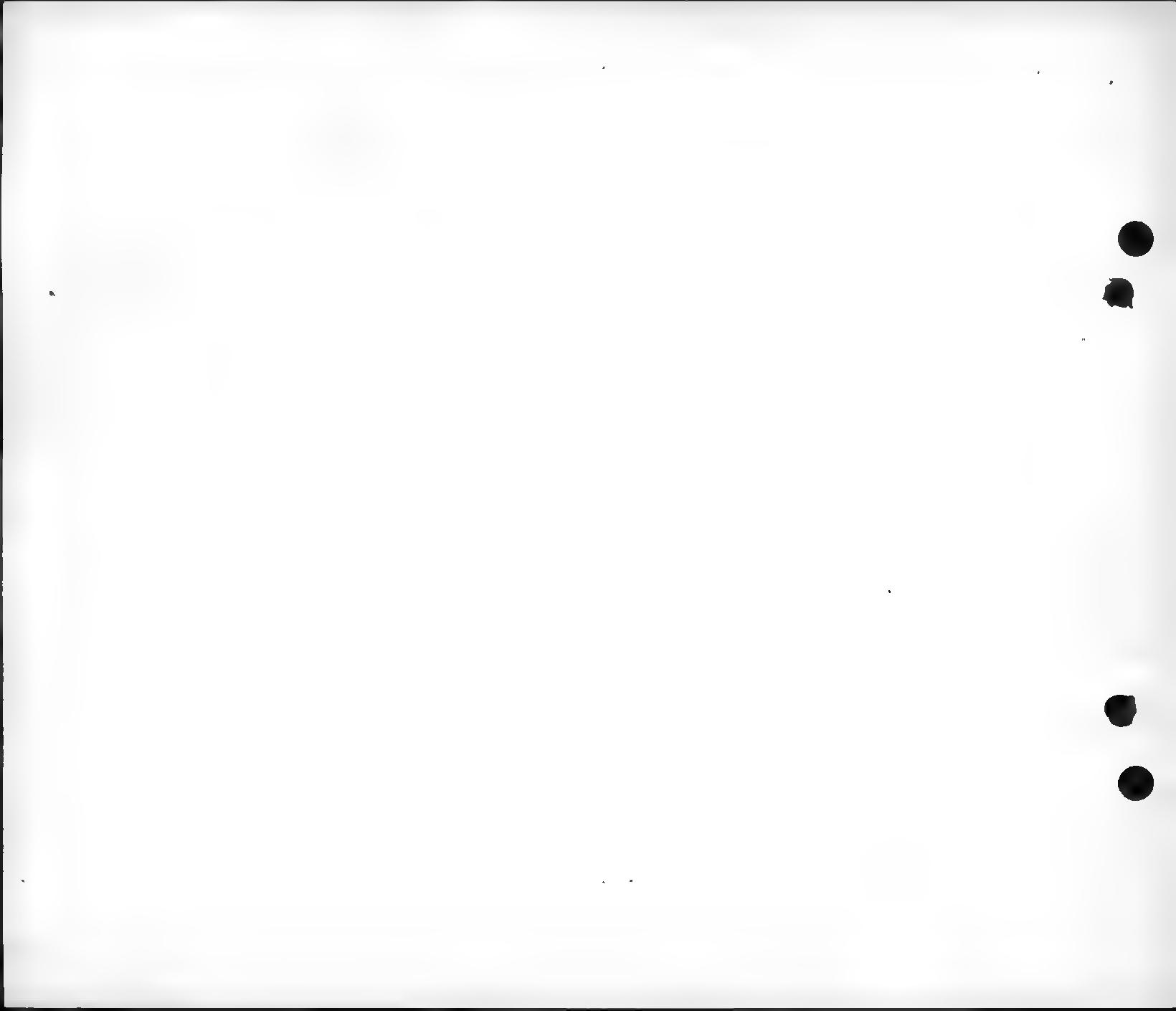
ADDRESS

24. FUNERAL DIRECTOR

ADDRESS

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 45

## 1. PLACE OF DEATH:

COUNTY BALTO.

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
TOWN Middle River - 21LENGTH OF STAY  
(in this place)HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS3. NAME OF  
DECEASED:  
(Type or Print)

(First)

(Middle)

(Last)

5. SEX:

m

6. COLOR OR  
BACK:

BACK:

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify): MARRIED

8. DATE OF BIRTH:

Sept 7-1973

4. DATE  
OF  
DEATH

Fin 20

19 6

19 6

19 6

19 6

19 6

19 6

9. AGE last birthday:

IF UNDER 1 YEAR

82 yrs

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
even if retired): ENGINEER10b. KIND OF BUSINESS OR  
INDUSTRY: B&O. RR11. BIRTHPLACE (State or foreign country): MD 12. CITIZEN OF WHAT  
COUNTRY?

## 13. FATHER'S NAME:

?

## 14. MOTHER'S MAIDEN NAME:

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: -

## 17. INFORMANT &amp; ADDRESS:

CLARA R. BROWN 49 DENTON ROAD

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) ...

DUE TO

CHRONIC myoarthritis

Antecedent cause(s)

Severity

Diseases or conditions, if any, (b) ...

giving rise to the above cause DUE TO

stating underlying cause last (c)

INTERVAL BETWEEN  
ONSET AND DEATHII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes  No 21a. EXTERNAL CAUSE WAS PRIMARY  or CONTRIBUTING  CAUSE OF DEATH.21b. PLACE (Home, farm, factory,  
of street, office bldg., etc.,  
INJURY)

21c. (City or town), (County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

M.

21e. INJURY OCCURRED  
While at Not while  
work  at work 

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

SIGNATURE:

CHIEF MEDICAL EXAMINER  
DEPUTY MEDICAL EXAMINER  
M. D. ASSISTANT MEDICAL EXAM.

DATE SIGNED

23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)  
REMOVAL (Specify): BURIAL 2/23/56 LORRAINE PARK WINDSOR MILL RD.

DATE REC'D BY LOCAL REG. DATE REC'D BY LOCAL REG.

REG. DATE REC'D BY LOCAL REG.

REG. DATE REC'D BY LOCAL REG.

REG. DATE REC'D BY LOCAL REG.

REG. DATE REC'D BY LOCAL REG.

REG. DATE REC'D BY LOCAL REG.

REG. DATE REC'D BY LOCAL REG.

REG. DATE REC'D BY LOCAL REG.



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01384

1424  
Item 2 Film G193 2-27-56

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

## 1. PLACE OF DEATH

COUNTY

Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL

OR

and give nearest town)

TOWN

Rockville

LENGTH OF STAY

(In this space)

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Marion Home

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

Maryland

COUNTY

Montgomery Co

CITY (If outside corporate limits, write RURAL and give nearest town)

OR

and give nearest town)

TOWN

Rockville

Rockville, Maryland

306 Sittings (If rural give location)

STREET

306 Sittings

ADDRESS

Montgomery Co

ADDRESS

Montgomery Co

Montgomery Co

Montgomery Co

ADDRESS

Montgomery Co

Montgomery Co

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## 1. IMMEDIATE CAUSE

(A)

Coronary Thrombosis

ANTECEDENT CAUSE(S) DUE TO  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

## 18. MEDICAL CERTIFICATION

INTERVAL BETWEEN  
ONSET AND DEATH

7 days.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES  NO 21a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

(B)

DUE TO

Home, farm, factory,  
OF INJURY street, office bldg., etc.)

## 21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

(M.)

at work

White  
Not white  
at work

## 21e. INJURY OCCURRED

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from

alive on 7/7/56, and that death occurred at 10:30 P.M. from the causes and on the date stated above.

SIGNATURE

Valerie T. Rees

ADDRESS (Street, city, town, state)

DATE SIGNED  
7/7/5623. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

Burial

## DATE THEREOF

2/10/56

## NAME OF CEMETERY OR Crematory

Woodlawn Cemetery

## LOCATION (City, town, or county)

Maryland

(State)

24. RECEIVED BY REGISTRAR

Frank Smith

## REGISTRAR'S SIGNATURE

Frank Smith

## 25. FUNERAL DIRECTOR'S SIGNATURE

Wm. Cook Jr.

## ADDRESS

127th Paul Rd

DATE

1956

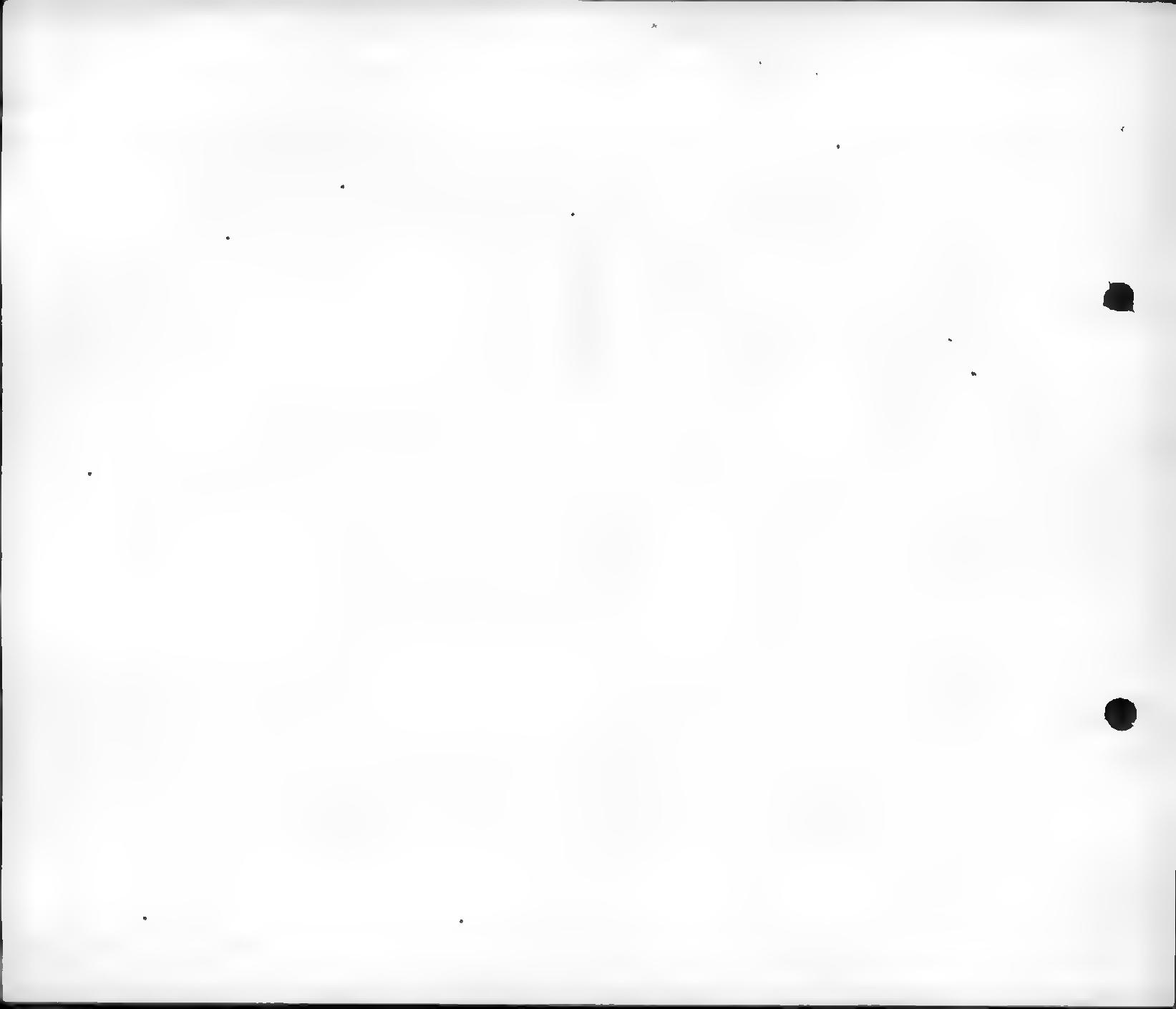


1425

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	COUNTY (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Smithwood & Summit Ave. Wayne Nursing Home	STREET ADDRESS	2110 Bolton St.
3. NAME OF DECEASED: (Type or Print)	(First) ANNA MIDDLE MARIE (Last) BUECHNER	4. DATE OF DEATH: F 9 5 10 19 56	
5. SEX: FEMALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): WIDOWED	8. DATE OF BIRTH: Oct. 21, 1877
10a. USUAL OCCUPATION Give kind of work done during most of working life, ever if retired):		10b. KIND OF BUSINESS OR INDUSTRY: at home	11. BIRTHPLACE (State or foreign country): Germany
13. FATHER'S NAME: John Malsy		14. MOTHER'S MAIDEN NAME: Kunigunda Hefner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: 17. INFORMANT & ADDRESS: Mr. Alexander Buechner-2110 Bolton St.	
18. MEDICAL CERTIFICATION			
<p>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>Immediate cause (a) DUE TO Fracture Hip Right</p> <p>Antecedent causes(s) (b) DUE TO Disseptis, cellulitis.</p> <p>Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last. (c) DUE TO Decubitus Ulcers Extensive.</p> <p>Sehile Demehfie</p>			
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION None		
20. AUTOPSY ? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY Hospital	(CITY OR TOWN) Spring Grove	COUNTY Hagerstown
TIME (Month) (Day) (Year) (Hour) OF INJURY 11/17/55 m.	INJURY SUFFERED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR? Fall out of Bed	(STATE) Md.
22. I hereby certify that I attended the deceased from 1 F 9 5 1956 to 10 F 25, 1956, that I last saw the deceased alive on 8 F 25, 1956, and that death occurred at 7:45 P.M., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED H. L. Hefner M.D. 1707 Edmonson Ave. Catonsville, Md. 2/19/56			
23. BURIAL, CREMATION, REMOVAL (Specify) Cremation	DATE THEREOF 2/13/56	NAME OF CEMETERY OR CREMATORIUM Green Mount Crem.	LOCATION (City, town, or county) Balto., Md. (State)
DATE RECD BY LOCAL REGISTRAR February 11, 1956	REGISTRAR'S SIGNATURE R. W.	24. FUNERAL DIRECTOR H. L. Hefner & Sons - Balto. 17	ADDRESS Md.



Reg. Dist. No. 32

## 1426 CERTIFICATE OF DEATH

Baltimore

## 1. PLACE OF DEATH:

COUNTY

MARYLAND

Catoctinville  
CITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
TOWNLENGTH OF STAY  
8 1/2 months  
(In this place)14. HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Spring Grove Hospital

3. NAME OF  
DECEASED:  
(Type or Print)(First) (Middle) (Last)  
MABLE LOUISE CARDWELL.

## 5. SEX:

F

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired):

## 13. FATHER'S NAME:

Howard Rige

15. WAS DECEASED EVER IN U.S. ARMED FORCES  
(Yes, no, or unk.) (If Yes, give war or dates  
of service)

NO

10B. KIND OF BUSINESS  
OR INDUSTRY:

Housewife

## 16. SOCIAL SECURITY NO.

213-10-1206

## 17. INFORMANT &amp; ADDRESS:

Eleanor Marshall white marsh, Maryland

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## IMMEDIATE CAUSE

(A)  
DUE TO

Acute Myocardial Failure (Post)

## ANTECEDENT CAUSE (S)

(B)  
DUE TO

Diabetes Mellitus.

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(C)

Generalized Arteriosclerosis with  
hypertension and cardiac enlargement.II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN  
ONSET AND DEATH21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
While  Not while   
at work  at work 

## 21F. HOW DID INJURY OCCUR?

M.

## 22. I hereby certify that I attended the deceased from June 18, 1955, to Feb 22, 1956, that I last saw the deceased

alive on Feb 22, 1956, and that death occurred at 11 P.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORIUM

## LOCATION (City, town or county)

## (State)

DATE REC'D BY LOCAL  
REGISTRAR

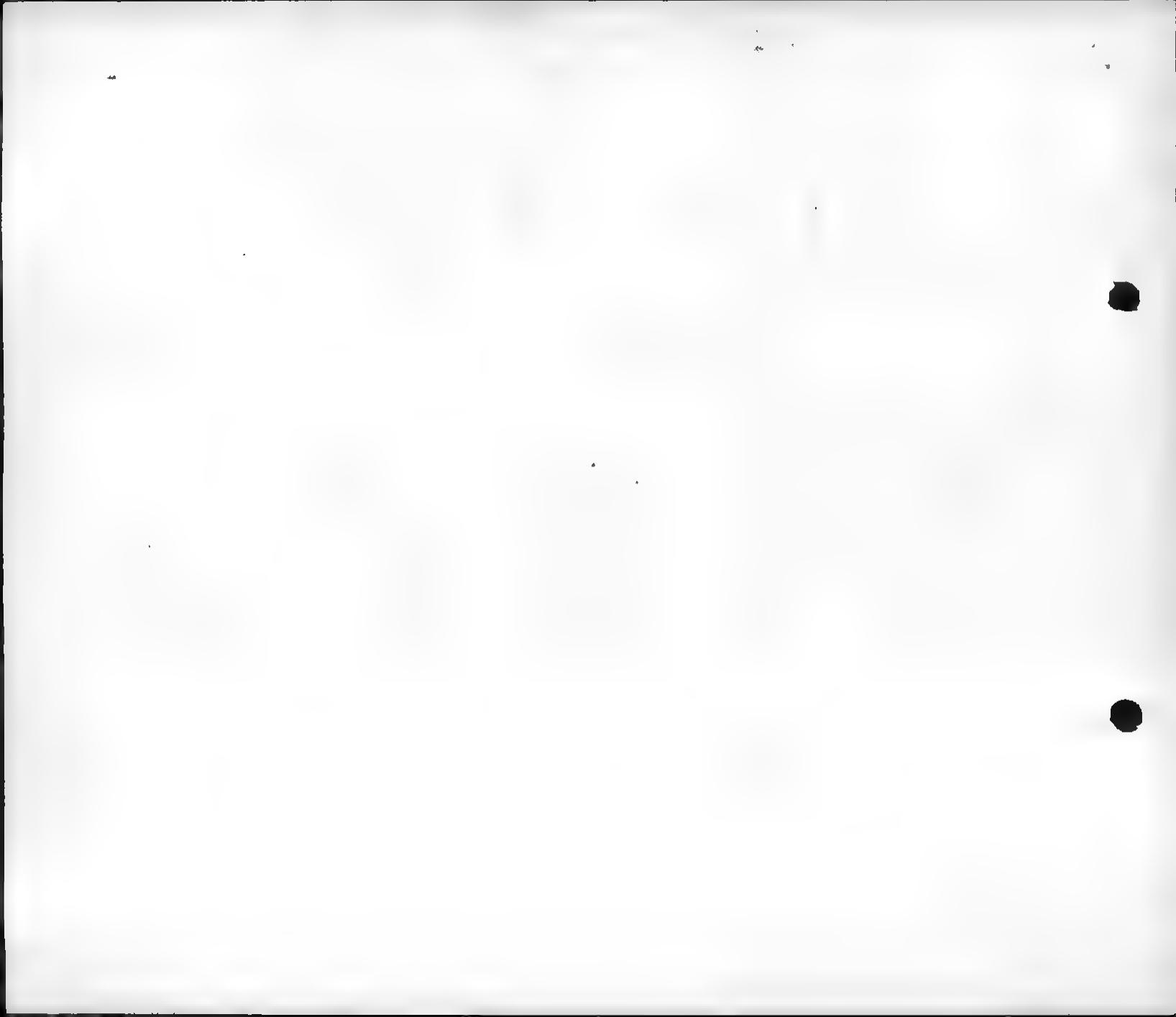
## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

2-24-56

Balto. Md. 2/22/56



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 1003 312-551

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
CITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
TOWN Town

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS 922 Roland View Avenue

3. NAME OF  
DECEASED:  
(Type or Print) WILHELM WALTER ALEXANDER CARROLL

5. SEX: Male 6. COLOR OR  
RACE: Colored

10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
even if retired): Private-Family

13. FATHER'S NAME:

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS:  
Maggie Carroll

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY  
CITY (If outside corporate limits write RURAL and give nearest town)  
OR  
TOWN Baltimore 1

STREET ADDRESS  
(If rural, give location)

507 Myrtle Avenue

4. DATE  
OF  
DEATH 2 9 19 56

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.  
51 yrs. Months Days Hours Min.

11. BIRTHPLACE (State or foreign country): Baltimore, Md. 12. CITIZEN OF WHAT  
COUNTRY? U.S.A.

14. MOTHER'S MAIDEN NAME:

Unknown

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.

Immediate cause (a) ....  
DUE TO

Coronary occlusion

INTERVAL BETWEEN  
ONSET AND DEATH

Antecedent cause(s)

Diseases or conditions, if any, (b)  
giving rise to the above cause DUE TO  
stating underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?  
Yes  No

(State)

21a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING  CAUSE OF DEATH. 21b. PLACE (Home, farm, factory,  
OF street, office bldg., etc.,  
INJURY)

21c. (City or town) (County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY M. 21e. INJURY OCCURRED  
While at work  Not while at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and  
find that death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined cause   
SIGNATURE

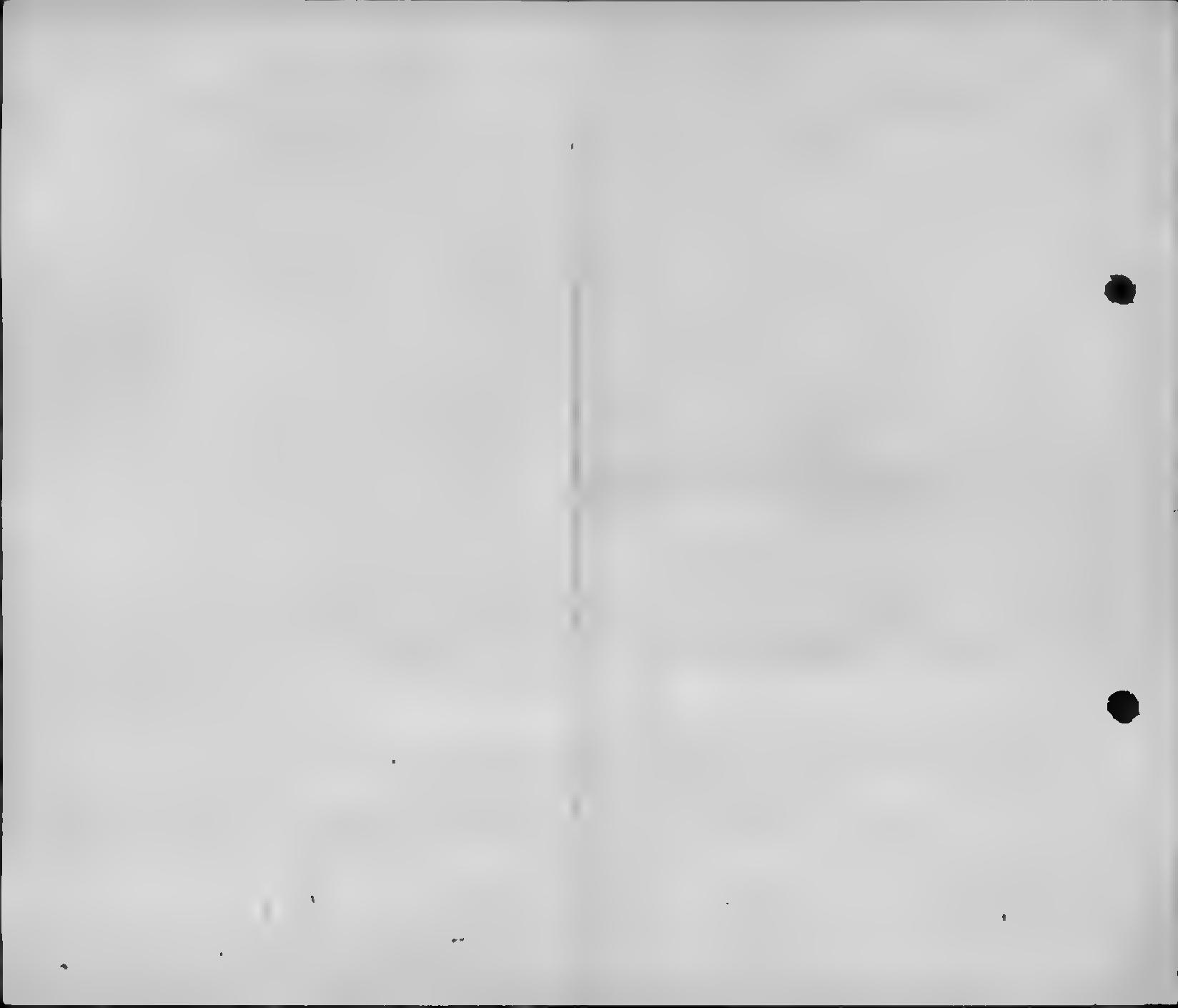
CHIEF MEDICAL EXAMINER  
DEPUTY MEDICAL EXAMINER  
M. D. ASSISTANT MEDICAL EXAM.

DATE SIGNED

2/19/56

23. BURIAL, CREMATION,  
REMOVAL (Specify): DATE THEREOF NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county)  
Cremation 2/12/56 Baltimore Nat Baltimore Md. (State)

DATE REC'D BY LOCAL REG. 2-13-56 REGISTER'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS  
E. J. Wilson



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01387

## 1428 CERTIFICATE OF DEATH

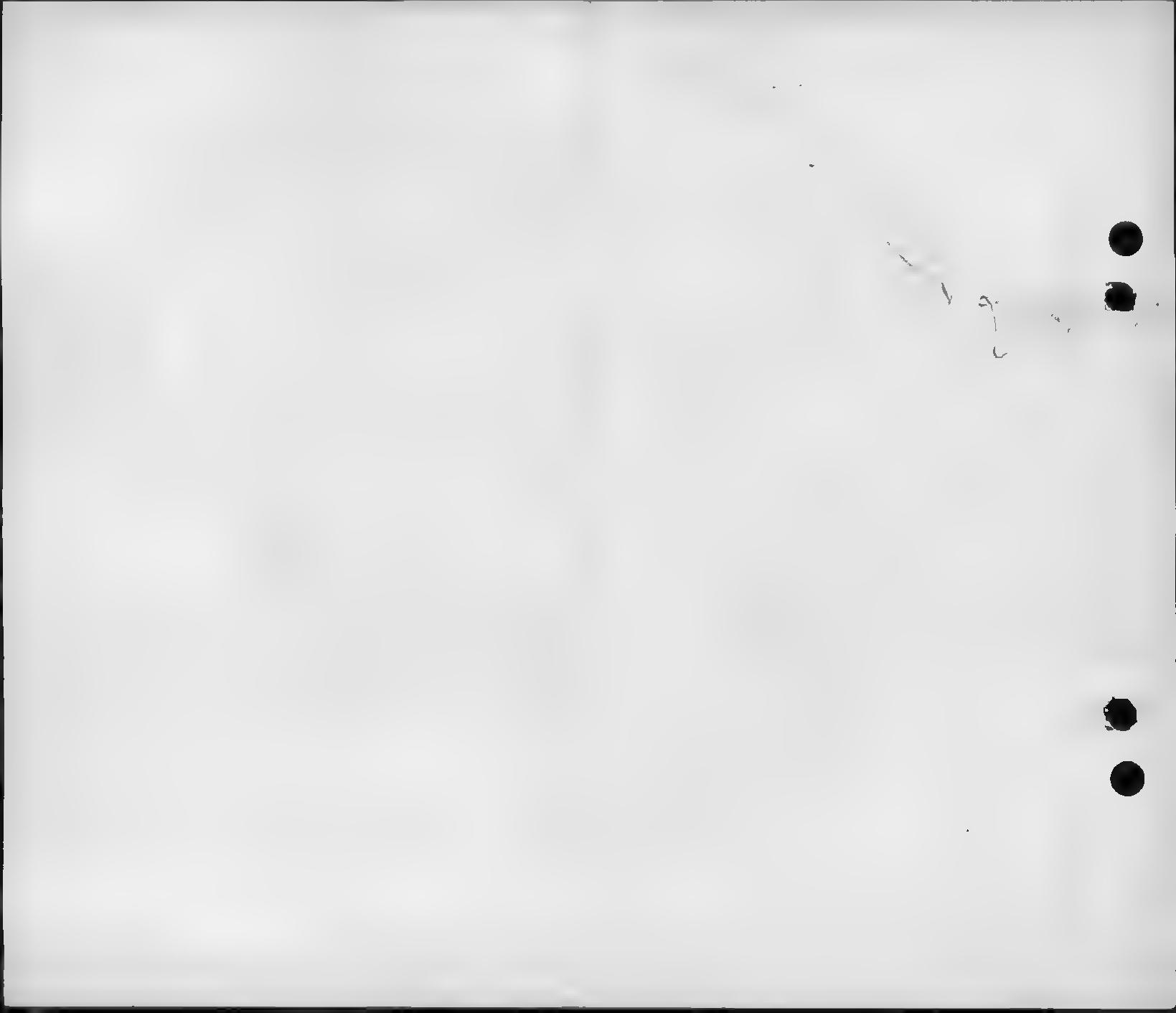
Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY BALTO. C. MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MD. COUNTY BALTO.	
CITY (If outside corporate limits, write RURAL and OR give nearest town) RURAL LENGTH OF STAY TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS 6112 Falls Rd.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MT. WASHINGTON STREET (If rural, give location) ADDRESS 6112 Falls Rd.	
3. NAME OF DECEASED (First) Robert FRANKLIN CARTER (Middle) R. (Type or Print)		4. DATE OF DEATH 2-16 1956	
5. SEX M.	6. COLOR OR RACE Bl.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH 8/4/1910
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY FISHING SCHOOL	9. AGE last birthday 35- yrs. If under 1 year Months 10 Days Hours Min.
13. FATHER'S NAME John CARTER		11. BIRTHPLACE (State or foreign country) RICHMOND VA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes FOR DEMON		12. CITIZEN OF WHAT COUNTRY USA	
16. SOCIAL SECURITY NO. 214-70-2975		17. INFORMANT AND ADDRESS wife	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  Immediate cause (a) Coronary Occlusion Antecedent cause(s) (b) Diabetes Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Obesity		INTERVAL BETWEEN ONSET AND DEATH 1 month	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT SUICIDE HOMICIDE TIME (Month) (Day) (Year) (Hour) INJURY	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY While at Work <input type="checkbox"/> At work <input type="checkbox"/>	(CITY OR TOWN)	(COUNTY) (STATE)
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2-16-1956 to 2-16-1956, that I last saw the deceased alive on 2-16-1956, and that death occurred at 9:30 A.M., from the causes and on the date stated above. SIGNATURE Chas Victor Leiberson. 321 Dean Leff Rd. B-2 2/16/56 ADDRESS DATE SIGNED			
23. BURIAL, CREMATION REMOVAL (Specify) BURIED	DATE THEREOF 2/20/56	NAME OF CEMETERY OR CREMATORIAL BURIAL NATIONAL BALT. MD.	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR Wm. L. CHATMAN, JR. 1201 MacClellan St. BALTO. MD.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

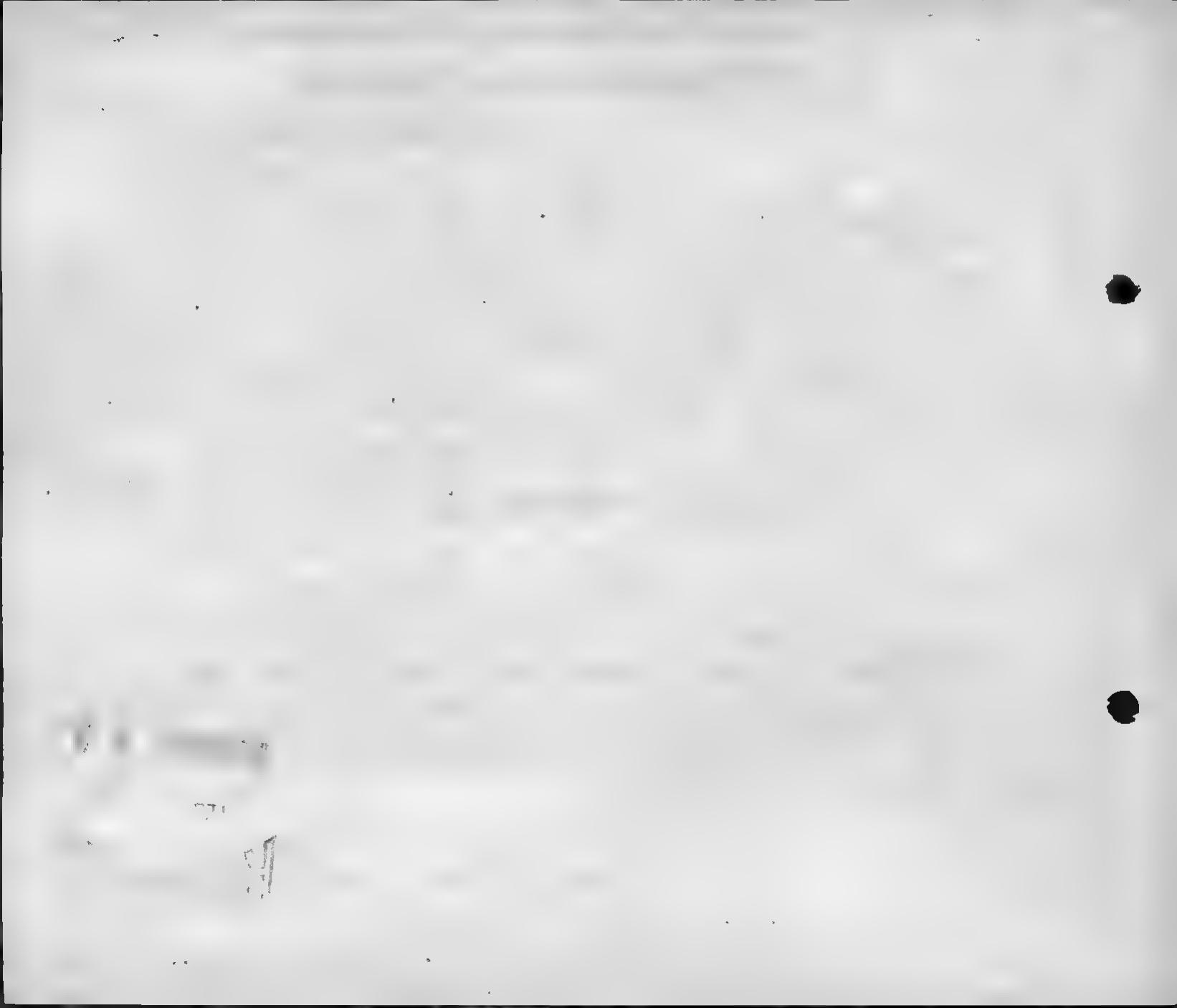
01388

## 1429 CERTIFICATE OF DEATH

Reg. Dist. No. 38

It is 12, PM, 293 3-5-56 et

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Baltimore Brooklandville,	MARYLAND LENGTH OF STAY (In this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS	28 yrs.		
Falls Road	Maryland County Baltimore Brooklandville		
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
[First] (Middle) [Last]		(Month) (Day) (Year)	
MARJORIE ALICE CASSELL		Feb. 20, 1956	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Female	White	married	March 30, 1980
9. AGE last birthday	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
75 yrs.	Housewife	Worcester, England	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Alfred Lucardo Wells	Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS	
NO	None	W. Barry Cassell, Brooklandville, Md.	
18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>Cerebral Vascular Accident</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerotic</i> <del>is</del> <i>Cardio-</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>vascular disease</i>			
19. INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. <input type="checkbox"/> at work <input type="checkbox"/> Not white <input type="checkbox"/> at work	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Aug. 15, 1955, to Feb. 20, 1956, that I last saw the deceased alive on Feb. 20, 1956, and that death occurred at 8:00 P.M. from the causes and on the date stated above. S. <i>Waverly Green</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)
Cremation		Feb. 22, 1956	Green Mount Crematory Baltimore, Maryland
24. READ BY REGISTRAR FEB 24 1956		REGISTRAR'S SIGNATURE <i>Mrs. Mabel Gray</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John O. Mitchell & Sons Inc., 1900 Eutaw Pl.



## 1430 CERTIFICATE OF DEATH

Reg. Dist. No. 0

## 1. PLACE OF DEATH:

COUNTY Balto. MARYLAND  
 CITY (If outside corporate limits, write RURAL  
 OR and give nearest town)  
 TOWN Catonsville

HOSPITAL OR  
 INSTITUTION OR Ridgeway Manor  
 STREET ADDRESS 5743 Edmondson Ave.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN Baltimore

STREET  
 ADDRESS  
 (If rural give location)

3. NAME OF  
 DECEASED:  
 (First) BERTHA (Middle) A. CHAMOW (Last)

5. SEX Female COLOR OR white 6. RACE widowed 7. SINGLE, MARRIED,  
 WIDOWED, DIVORCED.  
 (Specify)

## 8. DATE OF BIRTH

Feb. 22, 1896

9. DATE (Month) (Day) (Year)  
 OF  
 DEATH. Feb. 26, 1956

10. AGE last birthday 60 yrs  
 IF UNDER 1 YEAR  
 Months 0 Days 0 Hours 0 Min. 0

10A. USUAL OCCUPATION (Give kind of  
 work done during most of working life,  
 even if retired): Housewife at home

11. BIRTHPLACE (State or foreign country) Md.  
 12. CITIZEN OF WHAT  
 COUNTRY?

## 13. FATHER'S NAME:

Charles H. Heintzeman, Sr.

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
 (Yes, no, or unk.) (If Yes, give war or dates  
 of service)  
 NO none

## 18. SOCIAL SECURITY NO.

## 14. MOTHER'S MAIDEN NAME:

Amelia Yeakle

Clifton Park

## 17. INFORMANT &amp; ADDRESS.

Mr. Charles H. Heintzeman-Lake Cottage

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

## IMMEDIATE CAUSE

## 18. MEDICAL CERTIFICATION

INTERVAL BETWEEN  
 ONSET AND DEATH

## ANTECEDENT CAUSE (B)

Coronary Occlusion4 hours

DISEASES OR CONDITIONS, IF ANY,  
 GIVING RISE TO THE ABOVE CAUSE  
 STATING UNDERLYING CAUSE LAST

## (A) DUE TO

Arteriosclerotic Cardio-Vascular Disease

## (B) DUE TO

## (C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION. 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
 YES  NO 

21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
 (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory,  
 OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
 INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
 OF INJURY

## 21E. INJURY OCCURRED

## 21F. HOW DID INJURY OCCUR?

M. While  Not while at work  at work 

22. I hereby certify that I attended the deceased from 1956, to Feb. 26, 1956, that I last saw the deceased  
 alive on Feb. 26, 1956, and that death occurred at 11:30 A.M. from the causes and on the date stated above.  
 SIGNATURE Joy M. Zimmerman ADDRESS M. D 3202 Harford Rd DATE SIGNED Feb. 27, 1956

23. BURIAL, CREMATION,  
 REMOVAL (SPECIFY)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORIAL

## LOCATION (City, town, or county)

## (State)

Burial2/29/56Western Cem.Balto., Md.DATE REC'D BY LOCAL  
 REGISTRAR 2836

REGISTRAR'S SIGNATURE

14. FUNERAL DIRECTOR

ADDRESS

Wm. J. Pichard & Sons Mort. Hld.



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01330

1431

31

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH: Baltimore

County.....

City or town..... Woodlawn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 Years

Hospital, institution, or street address where death occurred.

1909 Kernan Drive

How long in hospital or institution?

## 3. (a) FULL NAME

CHARLES EMORY CHEUVRONT

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife..... Stephanie L. Cheuvront

7. Birth date of deceased (mo., day, yr.)

September, 20th. 1903

8. (c) If alive, give age 50 years

8. AGE: Years

Months

Days

52

4

26

hrs.

min.

9. Birthplace..... Dickeyville, Balto. Co. Md.

(Town, county, and state)

10. Usual occupation..... Ass't Chief Clerk

11. Industry or business..... B. &amp; O. R. R.

12. Name..... Charles William Cheuvront

13. Birthplace..... Martinsburg, West. Va.

14. Maiden name..... Ledia Electra Devese

15. Birthplace..... Woodlawn, Balto. Co. Md

16. Informant..... Mrs Charles Emory Cheuvront

Address 1909 Kernan Drive (7)

17. Burial..... Date thereof Feb. 20 1956

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... Lorraine Park Cemetery

Location..... Woodlawn, Balto. Co. Maryland

18. Funeral director..... Charles Lauro

Address 4510 Liberty Heights Avenue (7)

19. February 18 1956

(Date rec'd by registrar)

5 p.m.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore

City or town..... Woodlawn

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1909 Kernan Drive

(If rural, give LOCATION)

2. (a) If veteran, name-war? O NONE

## 3. (b) Social Security Number

705-03-8042

## MEDICAL CERTIFICATION

20. DATE OF DEATH February, 16th. 1956 3.30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Dec. 8 1955 to Feb. 15 1956

and that I last saw him alive on Feb. 16 1956

Immediate cause of death

Coronary thrombosis

DURATION

5 min.

Due to..... Cardio vascular disease

2 mos.

Due to..... Arterio sclerosis

? mos.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Gerald S. Lubell

M.D. or other

Address 2220 Garrison B'lvd. Date signed Feb. 17/56



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10AM

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01391

## 1432 CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED				
COUNTY CITY TOWN	Baltimore Sparks	MARYLAND LENGTH OF STAY (In this place)	STATE CITY TOWN	Md. Sparks	COUNTY Balto.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Belfast Road		STREET ADDRESS	Belfast Rd.		
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE (Month) OF DEATH February 3 (Year) 1956		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months Days Hours Min.	
Male	White	Married	29 June 1913	67 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Former	Farming	Sparks Balt Co. Md		21. S.A.		
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME					
George	Chilcoat		Ruth Brooks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS		INTERVAL BETWEEN ONSET AND DEATH		
NO	728-09-4544	wife - same		3 days		
18. MEDICAL CERTIFICATION						
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						
IMMEDIATE CAUSE (A)		Coronary thrombosis				
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		Arteriosclerotic Cardio-vascular disease 84 yrs				
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH						
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County)	(State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from alive on 3 Feb 1956, and that death occurred at 11 P.M. from the causes and on the date stated above.						19 Feb 1956 to 10 Feb 1956, that I last saw the deceased
SIGNATURE Walter T. Kees						ADDRESS (Street, city, town, state) Cockeysville Md
DATE SIGNED 3 February 1956						
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIUM		LOCATION (City, town, or county)		
Burial	2-6-56	Bosleys Methodist		Sparks, Balt Co. Md.		
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		
DATE 6 Feb 1956	Reine Armistead Mackay	J. Scott Brooks		Sparks, Md.		



**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

## 1433 CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Parkton</u> Rural LENGTH OF STAY (in this place)		TOWN <u>Parkton</u> Rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
Mt. Carmel.		Mt. Carmel.	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
Effie Pearl. Chicoat		February 11 1956	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Female	white	Married	July 22, 1887 68
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		Home	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Nicholas Mays		Margaret Wilhelm	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT & ADDRESS	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A)		Carcinoma Rectum-Primary 1 yr.	
ANTECEDENT CAUSES (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JAN 4 1955</u> to <u>February 11 1956</u> , that I last saw the deceased alive on <u>Feb 11 1956</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Joseph F. Bush M.D.</u> ADDRESS (Street, city, town, state) <u>Hamptonland</u> DATE SIGNED <u>2/11/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
Burial		Feb 14/56	
NAME OF CEMETERY OR CREMATORIAL		LOCATION (City, town, or county) (State)	
Salena W.B.		Baltimore Co Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE	
DATE <u>2-14-56</u>		REGISTRAR'S SIGNATURE <u>Mary B. Elkins</u>	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Edw. Stipton, Hamptoland Md			

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01393

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

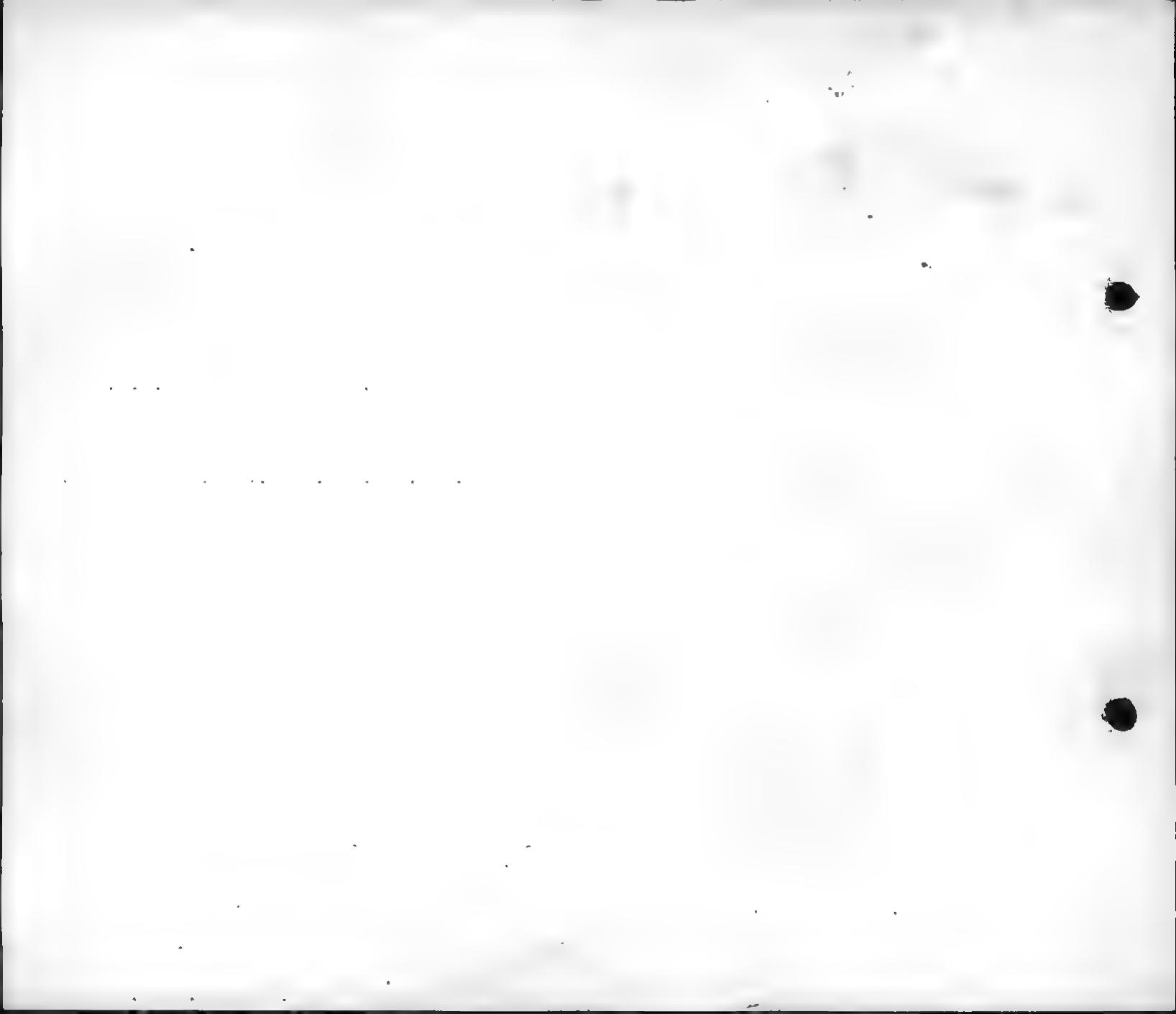
## 1434 CERTIFICATE OF DEATH

Reg. Dist. No. *X*

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH.			2. USUAL RESIDENCE (HOME) OF DECEASED:					
CITY OR TOWN		BALTIMORE MARYLAND	STATE CITY OR TOWN		MARYLAND COUNTY			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		135 1/4 Days			(If outside corporate limits, write RURAL and give nearest town)			
VETERANS ADMINISTRATION HOSPITAL			BALTIMORE			(If rural give location)		
3. NAME OF DECEASED: (Type or Print)		(First) JAMES (Middle) (NMI) (Last) CLEVELAND	4. DATE (Month) (Day) (Year)					
5. SEX: MALE		6. COLOR OR RACE: COLORED	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): SINGLE	8. DATE OF BIRTH: 8/14/1892	9. AGE last birthday: 65	10. KIND OF BUSINESS OR INDUSTRY: 1890		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER		10B. KIND OF BUSINESS OR INDUSTRY: UNION, S.C.			11. BIRTHPLACE (State or foreign country): U.S.A.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: JOHN CRAWFORD CLEVELAND			14. MOTHER'S MAIDEN NAME: ALANA NOTCH					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or date of service) Yes WW-I			16. SOCIAL SECURITY NO.					
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 002 IMMEDIATE CAUSE (A) FAR ADVANCED TUBERCULOSIS LEFT LUNG ANTECEDENT CAUSE (B) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)						UNKNOWN		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.								
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from Jan. 20, 1956 to Feb. 24, 1956, <i>Xxxxxxxxxxxxxxx</i> , and that death occurred at 7:15 P.M., from the causes and on the date stated above. ADDRESS <i>VAH, Fort Howard, Md.</i> DATE SIGNED <i>2/25/56</i> SIGNATURE <i>D. Mark</i>								
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			DATE THEREOF 2/28/56			NAME OF CEMETERY OR CREMATORIAL Baltimore National		
DATE REC'D BY LOCAL REGISTRAR <i>2/28/56</i>			REGISTRAR'S SIGNATURE <i>R. J. Frederick</i>			LOCATION (City, town, or county) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Charles R. Law Funeral Home						ADDRESS 802-04 Madison Ave., Balto., Md.		



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. After this bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A1SC 1-37-76

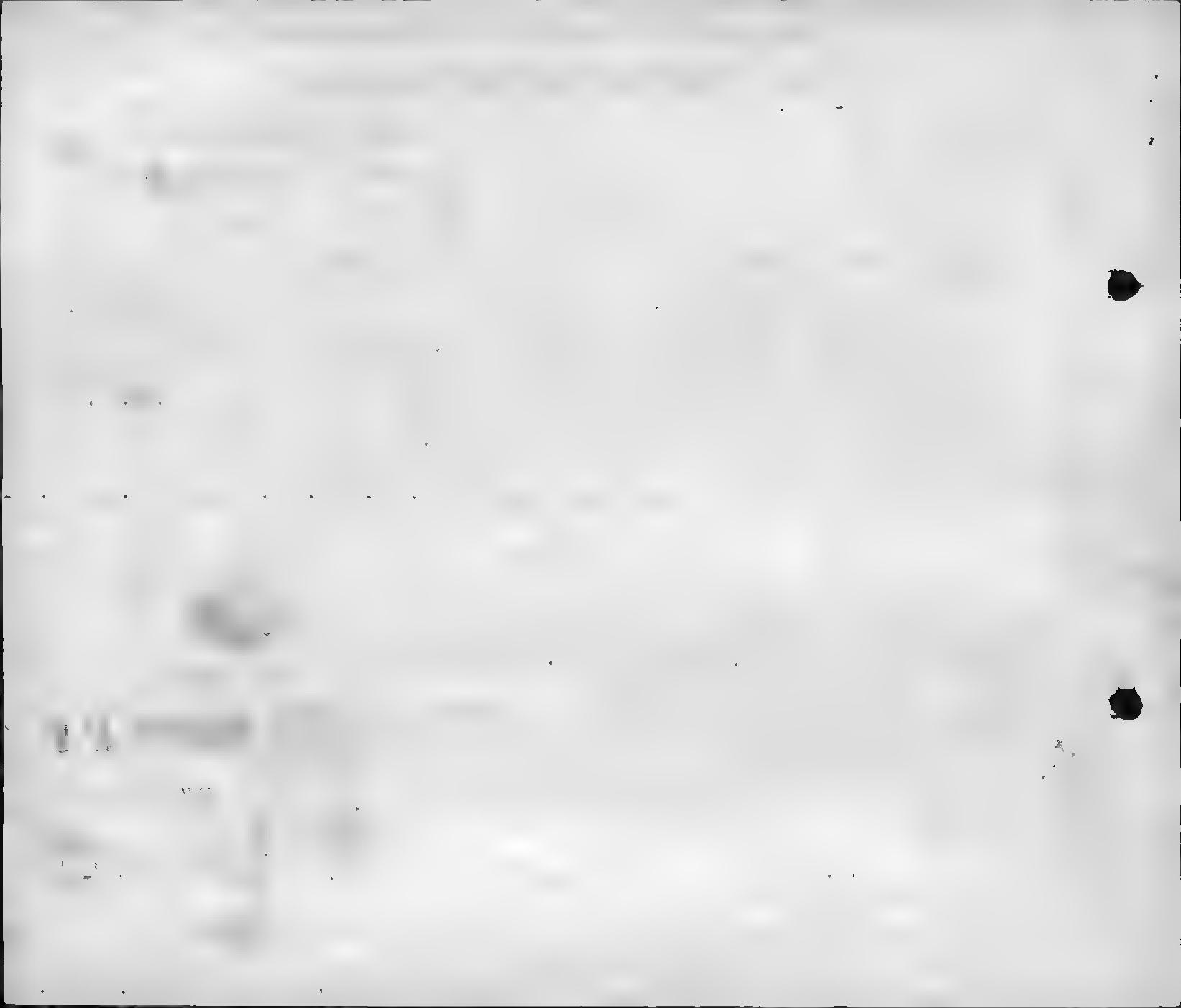
## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01394

## 1435 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town)	Baltimore MARYLAND	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town)	COUNTY Anne Arundel TOWN Annapolis
TOWN Fort Howard	LENGTH OF STAY (In this place) 971 Days	STREET ADDRESS 321 First Street	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		(If rural give location)	
<b>3. NAME OF DECEASED (Type or Print)</b> LAWRENCE W. COLLISON		<b>4. DATE OF DEATH</b> February 28 1956	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH September 19, 1899
9. AGE last birthday 56	10. IF UNDER 1 YEAR Yrs. Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handy Man		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (State or foreign country) Mayo, Maryland
13. FATHER'S NAME James Collison		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes <input checked="" type="checkbox"/> WW II		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT & ADDRESS Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.
<b>18. MEDICAL CERTIFICATION</b>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) PULMONARY EMPHYSEMA			
ANTECEDENT CAUSE(S) DUE TO HEALED FIBROCASEOUS TUBERCULOSIS			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) (C) UNKNOWN			
DISEASE OR CONDITION, DUE TO THE ABOVE CAUSE LAST. (C) UNKNOWN			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 1. COR PULMONALE 2. CIRRHOSIS OF LIVER			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
VA 22. I hereby certify that I attended the deceased from July 2, 1953, to Feb. 28, 1956, and that death occurred at 9:30 A.M. from the causes and on the date stated above SIGNATURE			
ADDRESS (Street, city, town, state)			
D. D. MARK, M.D.		M.D. VAH, FORT HOWARD, MARYLAND	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3-2-56	NAME OF CEMETERY OR CREMATORIUM Baltimore National Cemetery Baltimore, Maryland
24. REC'D BY REGISTRAR DATE MAR 5 1956		LOCATION (City, town, or county) (State)	
REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. Cook-Blight, Inc., 609 Harford Rd., Balto., Md.	



## **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

01395

1436

## **CERTIFICATE OF DEATH**

**Reg. Dist. No.**

44

executed within 24 hours

law requires that the health certificate be signed by a physician.

**ATTENDING PHYSICIAN** **HOSPITAL**  
The bottom copy may be retained by the hospital

executed within 24 hours after death.

law requires that the health certificate be signed by a physician.

**TO ATTENDING PHYSICIAN & HOSPITAL**

**FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been excused by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY BALTIMORE CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN FORT HOWARD HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STATE MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE STREET ADDRESS (If rural give location) 812 E. LOMBARD STREET	
3. NAME OF DECEASED (Type or Print) FRANCIS		4. DATE OF DEATH February 10, 1956	
(First) (Middle) (Last)		(Month) (Day) (Year)	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH JULY 30, 1893
9. AGE last birthday 62 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEWARD		10b. KIND OF BUSINESS OR INDUSTRY STEAMSHIP LINE	
11. BIRTHPLACE (State or foreign country) BROOKLYN, N. Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PATRICK CONNOR		14. MOTHER'S MAIDEN NAME ANNA KILLIAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk) YES (If Yes, give war or dates of service) WW-1		16. SOCIAL SECURITY NO. 054-07-1828	
17. INFORMANT & ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 15a. IMMEDIATE CAUSE CARCINOMA ESOPHAGUS		INTERVAL BETWEEN ONSET AND DEATH 1 YEAR (?)	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION 12-29-55	19b. MAJOR FINDINGS OF OPERATION GASTROSTOMY	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) VAH, Fort Howard, Maryland		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12-12-55, 1955, to 2-10-56, 1956, and that death occurred at 2:15 P.M., from the causes and on the date stated above. SIGNATURE C. COOK, M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 2-15-56	
DATE THEREOF 2-15-56		NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL CEMETERY BALTIMORE MARYLAND	
24. REC'D BY REGISTRAR DATE Feb. 14, 1956		REGISTRAR'S SIGNATURE Dawson L. Farley	
25. FUNERAL DIRECTOR'S SIGNATURE William Cook-Blight Inc. Funeral Home 6009 Harford Rd., Baltimore, Md.		ADDRESS	

BUREAU V. S.

FEB 15 1966

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01396

## 1437 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <i>Baltimore</i> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Towson</i>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>md</i> COUNTY <i>Baltimore</i> CITY: If outside corporate limits, write RURAL and give nearest town OR TOWN <i>Towson</i> STREET ADDRESS <i>713 Hillen Road</i> (If rural give location)			
3. NAME OF DECEASED: (First) <i>MARY</i> (Middle) <i>MATILDA</i> (Last) <i>CRONHARDT</i> (Type or Print)				4. DATE (Month) <i>2</i> (Day) <i>12</i> (Year) <i>1956</i> OF DEATH: 2 12 1956			
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>W</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (SPECIFY): <i>MARRIED</i>		8. DATE OF BIRTH: <i>Aug. 20, 1882</i> 9. AGE last birthday <i>73</i> yrs. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				11. BIRTHPLACE (State or foreign country) <i>Galesville, Md.</i> 12. CITIZEN OF WHAT COUNTRY? <i>md</i>			
13. FATHER'S NAME: <i>Peter Clement Siegel</i>				14. MOTHER'S MAIDEN NAME: <i>Matilda C. Siegel</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>—</i>				16. SOCIAL SECURITY NO. <i>—</i> 17. INFORMANT & ADDRESS: <i>Robinson Cronhardt 713 Hillen Rd. Towson</i>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>414X</i> IMMEDIATE CAUSE <i>Cardiac Decompensation</i> ANTECEDENT CAUSE (S) (A) DUE TO <i>Valvular disease of heart</i> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO <i>Rheumatism</i> (C) <i>—</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>—</i>							
19A. DATE OF OPERATION: <i>—</i> 19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>M.</i>		21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan 1957 to 2/12 1957</i> that I last saw the deceased alive on <i>2/11/57</i> , 1957, and that death occurred at <i>10:31 AM</i> , from the causes and on the date stated above. SIGNATURE <i>Dennis J. Mc Grath</i> ADDRESS <i>M. D. 8358 Loch Raven Blvd</i> DATE SIGNED <i>2/12/56</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Buried</i>		DATE THEREOF <i>Feb 14, 1956</i>		NAME OF CEMETERY OR CREMATORIAL <i>Woodfield</i>		LOCATION (City, town, or county) (State) <i>Galesville, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>2/13/56</i>		REGISTRAR'S SIGNATURE <i>John C. Mc Grath</i>		24. FUNERAL DIRECTOR <i>Bernard Hardisty</i>		ADDRESS <i>Galesville, Md.</i>	

RECEIVED

FEB 16 1955

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1438

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Baltimore Sorrenson Nursing Home 7912 Ruxway	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	MARYLAND Maryland Baltimore
3. NAME OF DECEASED: (Type or Print)		(First) ALONZA	(Middle) W.
4. SEX		5. COLOR OR RACE	6. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married
7. DATE OF BIRTH		8. AGE last birthday	
9. IF UNDER 1 YEAR Months Days		10. IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10B. KIND OF BUSINESS OR INDUSTRY: Building Const.	
11. BIRTHPLACE (State or foreign country): West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Daniel Cross			
14. MOTHER'S MAIDEN NAME:		15. SOCIAL SECURITY NO.	
16. INFORMANT & ADDRESS: Lyle W. Cross, 4521 Shamrock Avenue			
17. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) DUE TO			
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. General nutrition			
18. DATE OF OPERATION:		19. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OR OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		no injury	
22. I hereby certify that I attended the deceased from . . . . . , 19 . . . . . , to . . . . . , 19 . . . . . , that I last saw the deceased			
alive on . . . . . , 19 . . . . . , and that death occurred at . . . . . M, from the causes and on the date stated above. SIGNATURE: <i>James Graham Marton, M.D.</i> ADDRESS: DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
burial		2/22/56	
DATE REC'D BY LOCAL REGISTRAR		NAME OF CEMETERY OR CREMATORIAL REGISTRAR'S SIGNATURE	
Moreland Park Cemetery		LOCATION (City, town, or county) (State)	
Feb. 23, 1956		24. FUNERAL DIRECTOR ADDRESS	
John Cook, Inc.		1217 St. Paul St.	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 422

## 1. PLACE OF DEATH:

COUNTY

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
TOWN

MARYLAND

LENGTH OF STAY  
(in this place)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

COUNTY

Baltimore

CITY (If outside corporate limits write RURAL and give nearest town)  
OR  
TOWNSTREET  
ADDRESS

(If rural, give location)

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

1219 Maiden Choice Rd

1219 Maiden Choice Lane

3. NAME OF  
DECEASED:  
(Type or Print)

(First)

(Middle)

(Last)

4. DATE  
(Month) (Day) (Year)  
OF  
DEATH

July 1 1958

William S. Cullender

Married

July 8, 1905

48 yrs.

Months Days Hours Min.

m w

6. COLOR OR  
RACE7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

8. DATE OF BIRTH:

10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
even if retired):10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT  
COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MARRIED NAME:

William Cullender

— O'neill

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.)(If Yes, give war or dates of  
service)

16. SOCIAL SECURITY NO:

17. INFORMANT &amp; ADDRESS:

John M. Cullender 1219

Maiden Choice Lane

18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN  
ONSET AND DEATH

Immediate cause (a) \_\_\_\_\_

DUE TO

Antecedent cause(s) (b) \_\_\_\_\_

Diseases or conditions, if any, (b) \_\_\_\_\_

giving rise to the above cause DUE TO

stating underlying cause last (c) \_\_\_\_\_

Coronary Thrombosis

2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

3. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

21a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING  21b. PLACE (Home, farm, factory,  
cause of death. OF street, office bldg., etc.,  
INJURY)

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
OF While at Not while  
INJURY M. work  at work 

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , andfind that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .SIGNATURE *Herb Kieffer* 1010 Leads on

CHIEF MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

M. D. ASSISTANT MEDICAL EXAM

DATE SIGNED

23. BURIAL, CREMATION,  
REMOVAL (Specify): DATE THEREOF NAME OF CEMETERY OR CREMATORIUM LOCATION (City, town, or county)  
(State)

Burial 2-4-56 London Park Baltimore

Cremation *Herb Kieffer* 4107 ADDRESS

REG. DATE REC'D BY LOCAL REGIS. &amp; DIRECTOR

RECEIVED *Herb Kieffer* 4107 ADDRESS

23

100 200 300

## 1439 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH: COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Pa.</i> COUNTY <i>Burkes</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		STREET ADDRESS (If rural, give location)	
TOWSON				Reading		1338 Mineral Spring Rd.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		1721 Glen Ridge Rd.					
3. NAME OF DECEASED: (First) <i>George</i> (Middle) <i>Washington</i> (Last) <i>Davis</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>Feb. 4 1956</i>			
5. SEX: <i>Male</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <i>Widowed</i>		8. DATE OF BIRTH: <i>July 1, 1874</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tailor-ret. Retail Clothing</i>				10B. KIND OF BUSINESS OR INDUSTRY: <i>Penna.</i>			
11. BIRTHPLACE (State or foreign country): <i>Penna.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME: <i>Franklin Davis</i>				14. MOTHER'S MAIDEN NAME: <i>Emma James</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give year or dates of service) <i>None</i>				16. SOCIAL SECURITY NO.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Cerebro vascular accident</i> INTERVAL BETWEEN ANTECEDENT CAUSE (B) DUE TO <i>Arterio sclerotic cardio vascular disease</i> ONSET AND DEATH DUE TO <i>3 days</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) <i>Miller Funeral Home</i>		21C. WHERE DID (City or town) INJURY OCCUR? <i>Reading, Penna.</i>		(County) <i>M. D.</i> (State) <i>Pa.</i>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>M.</i>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1/5/56</i> to <i>2/4/56</i> , that I last saw the deceased alive on <i>2/4/56</i> , and that death occurred at <i>5:20 P.M.</i> from the causes and on the date stated above. SIGNATURE <i>John Gran</i> ADDRESS <i>M. D. 85 1/3 Fox River Blvd.</i> DATE SIGNED <i>2/15/56</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>		DATE THEREOF <i>Feb. 7, 1956</i>		NAME OF CEMETERY OR CREMATORIAL <i>Miller Funeral Home</i>		LOCATION (City, town, or county) <i>Reading, Penna.</i> (State) <i>Pa.</i>	
DATE REC'D. BY LOCAL REGISTRAR <i>2/17/56</i>		REGISTRAR'S SIGNATURE <i>G. M. Beacon</i>		24. FUNERAL DIRECTOR		ADDRESS <i>Jim Burns' Sons, Towson, Md.</i>	

321 37001

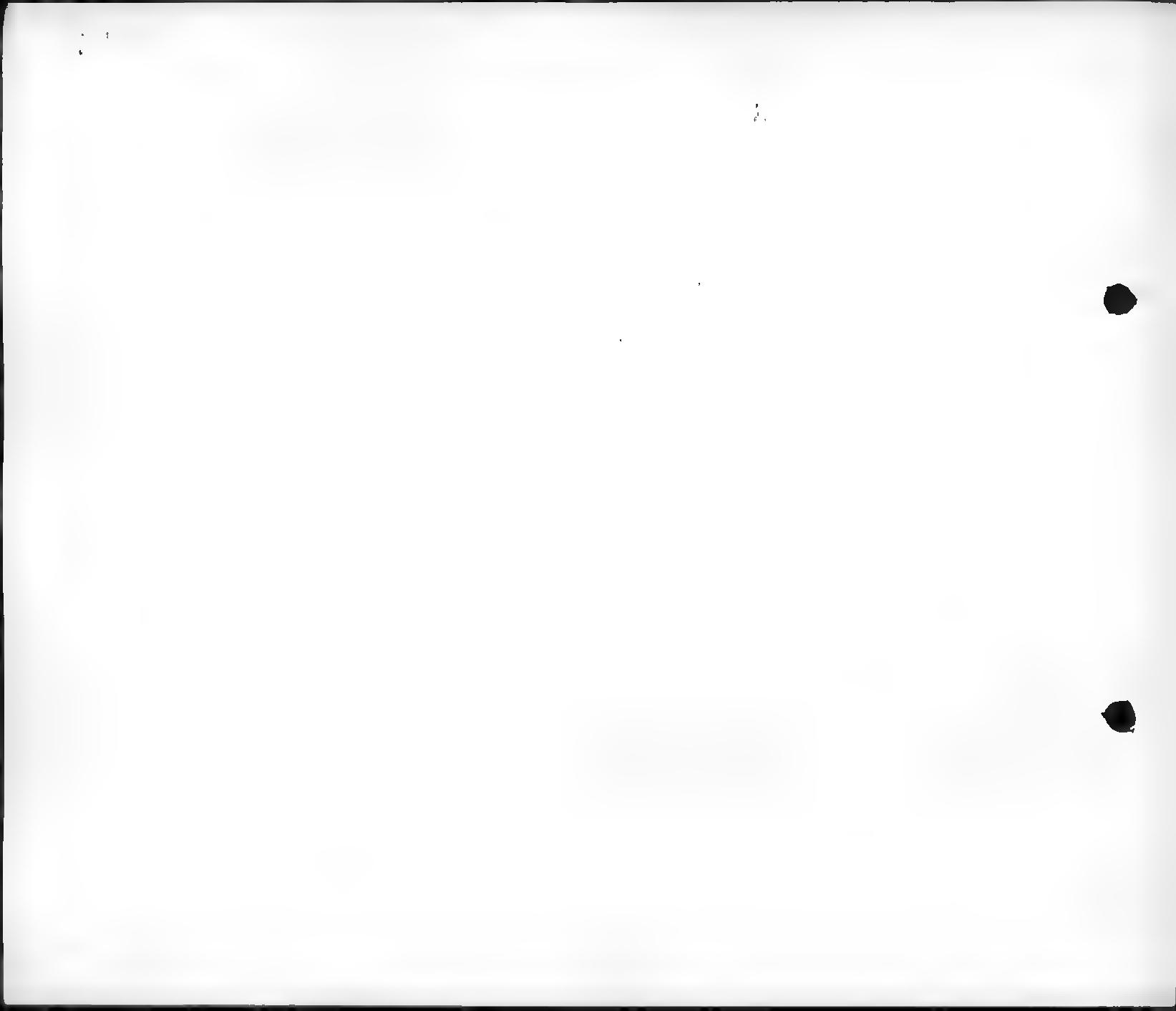


C7

## 1333 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND CITY (If outside corporate limits, write RURAL or and give nearest town) TOWN Dundalk				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Dundalk			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2914 Dunn Murray Road				STREET ADDRESS (If rural give location) 2914 Dunn Murray Road			
3. NAME OF DECEASED: (First) JOHN (Middle) MELVIN (Last) DAVIS		4. DATE OF DEATH: Feb. 4, 1956					
5. SEX: Male COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married		8. DATE OF BIRTH: Jan. 22, 1879		9. AGE last birthday: 77	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired. Carpenter		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: George H. Davis				14. MOTHER'S MAIDEN NAME: Adeline Lilly			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No.		16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS: Dr. M.B. Davis 6800 Mornington Road. 22			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) DUE TO Arterio-Deterotic-Cardio-Vascular							
Antecedent causes (s) (b) DUE TO Renal Disease							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None							
19a. DATE OF OPERATION:		19b. MAJOR ENDINGS OF OPERATION		20. AUTOPSY <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN)		(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At Work <input type="checkbox"/>		HOW DID INJURY OCCUR? ADDRESS DATE SIGNED			
22. I hereby certify that I attended the deceased from Jan. 23, 1956, to Feb. 4, 1956, that I last saw the deceased alive on Feb. 4, 1956, and that death occurred at 6:15 P.M., from the causes and on the date stated above.							
SIGNATURE (Degree or title) ADDRESS DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF Feb. 7, 1956		NAME OF CEMETERY OR CREMATORIUM Trinity Episcopal Church		LOCATION (City, town, or county) Churchville, Md. (State)	
DATE RECD BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Feb. 7, 1956		O. H. Ulrich		Ulrich Funeral Home		2112 Dundalk Ave.	



## 1441 CERTIFICATE OF DEATH

Reg. Dist. No. 40

## 1. PLACE OF DEATH

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN Baltimore Co Md Life  
 HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS 2809 E Joppa Rd

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md COUNTY Baltimore  
 CITY (If outside corporate limits, write RURAL, and give nearest town)  
 OR  
 TOWN Baltimore Co. Md  
 STREET ADDRESS 2809 E Joppa Rd  
 (If rural give location)

## 3. NAME OF DECEASED: (First) (Middle) (Last)

(Type or Print) Clarence F. Debrieng(Specify) male white6 COLOR OR RACE white7. MARRIED, WIDOWED, DIVORCED WIDOWED(Specify) Divorced8. DATE OF BIRTH Dec 7-1877

9. AGE last birthday IF UNDER 1 YEAR

Months 78 yrs Days 0 Hours 0 Mln. 010A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk Koppers Co.10B. KIND OF BUSINESS OR INDUSTRY Koppers Co.11. BIRTHPLACE (State or foreign country) Baltimore Md12. CITIZEN OF WHAT COUNTRY USA13. FATHER'S NAME Anthony Debrieng14. MOTHER'S MAIDEN NAME Regina Bluebaespies15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) No16. SOCIAL SECURITY NO. 21507-62-581117. INFORMANT & ADDRESS Meta Krafft 2809 E Joppa Rd

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 450.0IMMEDIATE CAUSE Congestive Heart FailureANTECEDENT CAUSE (B) Cardiac decompensation

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST Cachexia & arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING

TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 0

## 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? NOYES  NO 

OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

(Specify) None21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)(Specify) None

21B. PLACE (Home, farm, factory

OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? Home(City or town) Baltimore(County) Md(State) Md21D. TIME (Month) (Day) (Year) (Hour) Feb 19 55OF INJURY AMM. Whiteat work  at work 21E. INJURY OCCURRED Feb 19 55While  Not while at work  at work 21F. HOW DID INJURY OCCUR? Frominjury fall

22. I hereby certify that I attended the deceased from

alive on Feb 1, 1956SIGNATURE Frank J. Rankinand that death occurred at 9:00 AMM. D. Frank J. RankinDATE REC'D BY LOCAL REGISTRAR 2-9-56REGISTRAR'S SIGNATURE John HammethADDRESS 17401 Belair Rd23. BURIAL, CREMATION, REMOVAL, (SPECIFY) BurialDATE THEREOF 2/9/56NAME OF CEMETERY OR CREMATORIAL Parkwood CemLOCATION (City, town, or county) Baltimore(State) Md24. FUNERAL DIRECTOR Lassahn Funeral HomeADDRESS 7401 Belair Rd

Dr. Nasir A  
Hoc 5 Haar - 202

• JEWELRY V. S

TEB

RECEIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 30

## 1. PLACE OF DEATH:

COUNTY

BALTIMORE

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN

Catonsville

LENGTH OF STAY  
(in this place)

1 year

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

112 Malbrook Road

3. NAME OF  
DECEASED:  
(Type or Print)

(First)

(Middle)

(Last)

LILLIAN C PEICHMOLLER

4. DATE  
OF  
DEATH

FEB 3 1956

(Month) (Day) (Year)



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01404

## 1443 CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Essex</i>		b. COUNTY <i>Baltimore</i>		
c. LENGTH OF STAY IN 1B <i>10 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Essex</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>313 Lorraine Ave</i>		d. STREET ADDRESS <i>313 Lorraine Ave</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Anna</i>	Middle <i>E.</i>	Last 4. DATE OF DEATH <i>Feb. 29th 1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 8th 1896</i>	
9. AGE (In years (last birthday) <i>59 yrs.</i>		10. IF UNDER 1 YEAR Months <i>5</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>housewife</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Adam Hartman</i>		
14. MOTHER'S MAIDEN NAME <i>Eva H. Lechner</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		
16. SOCIAL SECURITY NO <i>None</i>		17. INFORMANT <i>Mrs. Emma Dunham</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  DUE TO (b) DUE TO (c)		Cerebral hemorrhage Hypertensive Cardio-Vascular disease INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i> <i>9 yrs</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month <i>April</i>	Day <i>19</i>	Year <i>1956</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Baltimore</i>	(County) <i>Md.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>April 19, 1956</i> to <i>Feb 29, 1956</i> , that I last saw the deceased alive on <i>Feb 25, 1956</i> , and that death occurred at <i>5:55 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>423 Eastern Ave</i>		
ACTUAL SIGNATURE <i>Joseph Nical M.D.</i>	DATE SIGNED <i>3/1/56</i>			
PHYSICIAN'S NAME (Type) <i>JOSEPH NICEL M.D.</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/10/56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore National</i>	22d. LOCATION (City, town, or county) <i>Baltimore City</i>	(State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lawrence Laurel Hare</i>	ADDRESS <i>7401 Belair Rd.</i>	24a. REC'D BY REGISTRAR DATE <i>5 1956</i>	24b. REGISTRAR'S SIGNATURE <i>Edith Harleys</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-trust permit. Then please remove carbon copies. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

FEDERAL BUREAU OF INVESTIGATION

MAR 5 1968

W. E. B. DAVIS

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01405

1444

## CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>		b. COUNTY <b>BALTC.</b>	
c. LENGTH OF STAY IN 1b <b>40 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>301 CANDY TERRACE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>CASIMIR</b>	Middle <b>DOLATA</b>	Last Month Day Year <b>2 22 1956</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 17, 1888</b>
9. AGE (in years last birthday) <b>68 yrs</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>POLAND</b>
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>4221</b>		16. SOCIAL SECURITY NO <b>123-09-15847</b>	
17. INFORMANT <b>Michaelina Dolata (Same)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Pulmonary edema</b>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Cardiac failure</b>			
DUE TO (b) <b>Cardio-vascular disease</b>			
DUE TO (c) <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p.m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2-20</b> , 19 <b>56</b> , to <b>2-22</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>2-22</b> , 19 <b>56</b> , and that death occurred at <b>6-15 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Maxwell H. Mund</b>		ADDRESS (Street, city or town, state) <b>1017½ Eastern Ave., Baltimore, Md.</b>	
PHYSICIAN'S NAME (Type) <b>MAXWELL H. MUND</b>		DATE SIGNED <b>2-23-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-25-1956</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Sacred Heart</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jacob J. Connolly</b>		24a. REC'D BY REGISTRAR <b>7</b>	24b. REGISTRAR'S SIGNATURE <b>Mrs. Edith Shultz</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

(4)



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1445

## CERTIFICATE OF DEATH

01406

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 204 MINTERS LANE		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE	
3. NAME OF DECEASED (Type or print) ELLA		d. STREET ADDRESS 204 MINTERS LANE	
First MIDDLE		Last DORSEY	
4. DATE OF DEATH FEB. 15th,	Month	Day	Year 1955
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/10/1901
9. AGE (in years last birthday) 54 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
11. BIRTHPLACE (State or foreign country) FREDERICK COUNTY, MD.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME JAMES BRUNER		14. MOTHER'S MAIDEN NAME CLARA NORRIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 111-11-1111	
17. INFORMANT JOHN H. DORSEY-204 MINTERS LANE		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which arose, rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Glomerulonephritis		INTERVAL BETWEEN ONSET AND DEATH 7 days 5-6 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) No		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> , 1955, to <u>16 Nov</u> , 1955, that I last saw the deceased alive on <u>16 Nov</u> , 1955, and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) Charles R. Davidson M.D. 204 MINTERS LANE		DATE SIGNED 16 Nov 1955	
ACTUAL SIGNATURE CHARLES R. DAVIDSON M.D.		PHYSICIAN'S NAME (Type) CHARLES R. DAVIDSON M.D. 204 MINTERS LANE, CATONSVILLE, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/56	
22c. NAME OF CEMETERY OR CREMATORIAL EATON TOWNSHIP, MD.		22d. LOCATION (City, town, or county) CATONSVILLE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Hurley-512 (dweller at)		ADDRESS DATE FEB 20 1956	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE V.E. Harry	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1530

## CERTIFICATE OF DEATH

01500  
33

Reg. Dist. No.

PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Upperco (Rural)</i>		c. LENGTH OF STAY IN 1b <i>13 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>OR INSTITUTION</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Upperco</i>	
d. STREET ADDRESS <i>1100 Upperco Rd</i>		d. STREET ADDRESS <i>Upperco</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>SALLIE - M - PORTER</i>		4. DATE OF DEATH <i>Feb 24 1956</i>	Month Day Year
5. SEX <i>F</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 2-1871</i>
9. AGE (In years last birthday) <i>84</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	11. IF UNDER 24 HRS Hours <i>0</i> Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housework</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Henry Fournier</i>		14. MOTHER'S MAIDEN NAME <i>Sydne Hoover</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Mr Earl Greene</i>	
17. INFORMANT <i>Mr Earl Greene</i>		Address <i>Upperco Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancerous of Pharynx - mouth</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 mo</i>	
DUE TO <i>1-8x</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b)</i>			
DUE TO <i>1-8x</i>			
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 23 1955</i> to <i>Feb 24 1956</i> , that I last saw the deceased alive on <i>Feb 23 1956</i> , and that death occurred at <i>Hampstead, Md.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Hampstead, Md.</i> DATE SIGNED <i>2/25/56</i>	
ACTUAL SIGNATURE <i>M. C. Porterfield, M.D.</i>		PHYSICIAN'S NAME (Type) <i>M. C. PORTERFIELD, M.D.</i>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Feb 26/56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Stitz</i>	22d. LOCATION (City, town, or county) (State) <i>York Co - Pa</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edw Cipton</i>	ADDRESS <i>Hampstead Md</i>	24a. REC'D BY REGISTRAR DATE <i>2-24-56</i>	24b. REGISTRAR'S SIGNATURE <i>Doris B. Elmer</i>

TO HOSPITAL OR ATTENDING PHYSICIAN  
may be retained by the hospital  
or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 3 should be detached for use as the burial or removal permit. This form is to be used in the event of burial, cremation, or removal.

15S A15 (4)  
9/95

24 hours after death. Page 4

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN & HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

## **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

01407

**1446 CERTIFICATE OF DEATH**

**Reg. Dist. No**

<b>1. PLACE OF DEATH</b> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bentley Springs</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b> STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS			
<b>3. NAME OF DECEASED</b> (First) <u>Morgan</u> (Middle) <u>E.</u> (Last) <u>Doster</u> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) <u>Febr</u> (Day) <u>17</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	7. DATE OF BIRTH <u>Nov. 7, 1877</u>	8. AGE last birthday <u>78</u>	9. IF UNDER 1 YEAR Yrs. <u>0</u> Months <u>0</u> Days <u>0</u>	10. IF UNDER 24 HRS. Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Track Foreman Railroad</u>	11. BIRTHPLACE (State or foreign country) <u>Parkton, Md. R.R. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
<b>13. FATHER'S NAME</b> <u>Edward Doster</u>				<b>14. MOTHER'S MOTHER'S NAME</b> <u>Mary Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS <u>Mrs. Bessie Doster, Bentley Springs</u>			
<b>18. MEDICAL CERTIFICATION</b> I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>acute congestive heart failure.</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) <u>Diabetes Mellitus</u> GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>2601</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>							
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County)	(State)
21d. TIME OF INJURY (Month) <u>Febr</u> (Year) <u>1956</u> (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>7-30-1955</u> to <u>2-17-1956</u>, that I last saw the deceased alive on <u>2-17-1956</u>, and that death occurred at <u>9:53 A.M.</u> from the causes and on the date stated above.  <b>SIGNATURE</b> <u>R. Robinson, M.D.</u> <b>ADDRESS</b> (Street, city, town, state) <u>New Freedom, Pa.</u> <b>DATE SIGNED</b> <u>2-18-56</u> </b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Febr 20 1956</u>		NAME OF CEMETERY OR CREMATORIUM <u>Mt. Zion Cemetery, Freeland</u>		LOCATION (City, town, or county) <u>Md.</u> (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Collier L. Buderick, Jacob Hartenstein</u>		ADDRESS	
DATE <u>20/2/1956</u>							

1-10341-2

FEB 21 1968

15G

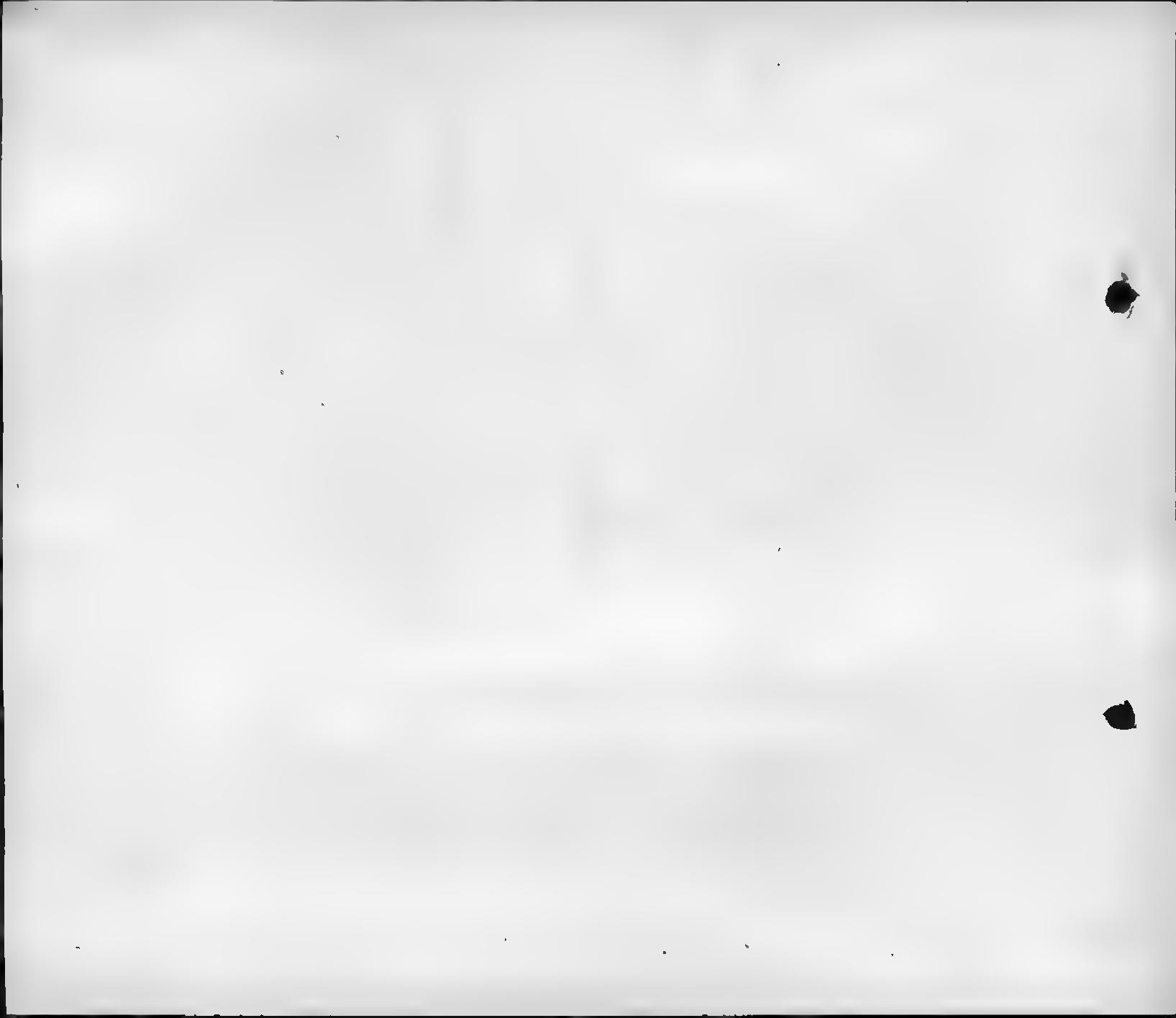
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01408  
**1447 CERTIFICATE OF DEATH** Reg. Dist. No.

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town)		MARYLAND LENGTH OF STAY (In this place)		STATE CITY (If outside corporate limits, write RURAL and give nearest town)		MD. COUNTY BALTIMORE	
TOWN EASTWOOD		6 DAYS		OR TOWN BALTIMORE		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 445 PEMBROKE BLVD				STREET ADDRESS 121 S. BOULDIN ST.			
3. NAME OF DECEASED: (Type or Print)		(First) MARY (Middle) ELIZABETH (Last) DOULONG		4. DATE OF DEATH Feb., 3, 1956		(Month) (Day) (Year)	
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed		8. DATE OF BIRTH January 31, 1885	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired		10B. KIND OF BUSINESS OR INDUSTRY: House Work		11. BIRTHPLACE (State or foreign country): Baltimore, Md.		9. AGE last birthday 71 yrs	
13. FATHER'S NAME: JOHN W. HERRIMAN		14. MOTHER'S MAIDEN NAME: CATHERINE STEINMETZ.		10. SOCIAL SECURITY NO.		11. IF UNDER 1 YEAR Months Days Hours Min.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no or unk.) (If Yes, give war or dates of service) No		16. MEDICAL CERTIFICATION		17. INFORMANT & ADDRESS: Catherine A. Scharpf 445 Pembroke		12. CITIZEN OF WHAT COUNTRY: U.S.A.	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Blvd.	
IMMEDIATE CAUSE		(A) DUE TO <i>Arteriosclerosis C.V. Disease</i>				INTERVAL BETWEEN ONSET AND DEATH Spt 11/55	
ANTECEDENT CAUSE (S)		(B) DUE TO <i>Myocardial Failure</i>				Jan 17/56	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>None</i>		19B. MAJOR FINDINGS OF OPERATION: <i>None</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) <i>None</i>		21C. WHERE DID INJURY OCCUR (City or town) <i>None</i>		(County) <i>None</i> (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>None</i>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>None</i>			
22. I hereby certify that I attended the deceased from <i>Sept 11, 1955</i> to <i>Feb 3, 1956</i> , that I last saw the deceased alive on <i>Feb 1, 1956</i> , and that death occurred at <i>11:30 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>S. A. Schenck</i> ADDRESS <i>M.D. 8424 East Ave</i> DATE SIGNED <i>7-4-56</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL 2-6-56</i>		DATE THEREOF <i>2-6-56</i>		NAME OF CEMETERY OR CREMATORIAL <i>DRUID RIDGE CEM. PIKESSVILLE, MD.</i>		LOCATION (City, town, or county) (State) <i>PIKESSVILLE, MD.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Feb 6, 1956</i>		REGISTRAR'S SIGNATURE <i>C. W. Hebrich</i>		24. FUNERAL DIRECTOR <i>Charles S. Miller</i>		ADDRESS <i>901 S. CONKLING ST. BALTO., MD.</i>	

**PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 - 10 - 53



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01410

## 1448 CERTIFICATE OF DEATH

Reg. Dist. No. 1

## 1. PLACE OF DEATH:

COUNTY

Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN

Woodlawn

LENGTH OF STAY  
(in this place)

16 years

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS3. NAME OF  
DECEASED:  
(Type or Print)

JOHN

(First)

(Middle)

(Last)

C. DYKE

4. SEX: 5. COLOR OR  
DECEASED:  
(Type or Print)

Male

White

7

SINGLE, MARRIED,  
WIDOWED, DIVORCED  
(Specify)

MARRIED

6. DATE OF BIRTH:  
DECEASED:  
(Type or Print)

Aug 16/1887

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Retired Steel Worker

10B. KIND OF BUSINESS  
OR INDUSTRY:

13. FATHER'S NAME:

John Dyke

15. WAS DECEASED EVER IN U.S. ARMED FORCES  
(Yes, no, or unk.) (If Yes, give war or dates  
of service)

16. SOCIAL SECURITY NO.

17. INFORMANT &amp; ADDRESS:

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A) CORONARY

THROMBOSIS

INTERVAL BETWEEN  
ONSET AND DEATH

1 HR.

ANTECEDENT CAUSE (B)

DUE TO

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(B)

ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE

5 YRS.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO 21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
While  Not while   
at work  at work 

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from DEC. 19, 1956, to FEB. 11, 1956, that I last saw the deceased  
alive on FEB. 11, 1956, and that death occurred at 10:30 P.M. from the causes and on the date stated above.  
SIGNATURE Mervin Goldstein ADDRESS M.D. 5334 Liberty Heights Ave. DATE SIGNED Feb. 12, 195623. BURIAL, CREMATION,  
REMOVAL (SPECIFY)DATE THEREOF  
NAME OF CEMETERY OR CREMATORIUMLOCATION (City, town, or county)  
(State)DATE REC'D BY LOCAL  
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

S-15-2 (Rev. 1-26-52) Harry M. Munoz 4204 Ridgewood Ave.



01411

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1384

## CERTIFICATE OF DEATH

Reg. Dist. No.

The correct age  
is especially important.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH. CITY OR TOWN INSTITUTION OR STREET ADDRESS		MARYLAND BALTIMORE 1925 Wareham Rd		2. USUAL RESIDENCE (HOME) OF DECEASED CITY (If outside corporate limits, write RURAL and give nearest town) TOWN STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)		(First) <i>Helen</i>	(Middle) <i>Dzielski</i> (Glass)	(Last) <i>Jane</i>	4. DATE OF DEATH 1956		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>Jan 18 86</i>	9. AGE last birthday 69 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. BIRTHPLACE (State or foreign country) <i>Poland</i>	12. CITIZEN OF WHAT COUNTRY? <i>Poland</i>
13. FATHER'S NAME <i>George Konopka</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Skrochki</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>216-16-8437 B My Finance Rice</i>			
16. SOCIAL SECURITY NO. <i>1825 Wareham Rd</i>							
17. INFORMANT <i>Mr. Francis Rice</i>							
18. MEDICAL CERTIFICATION							

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

19. a. Immediate cause <i>Heart Disease</i>	20. b. Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>Arteriosclerosis</i>
21. c. <i>None</i>	22. <i>None</i>

INTERVAL BETWEEN  
ONSET AND DEATH

10 days

15 days

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at m. Work <input checked="" type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *1956* to *1956*, that I last saw the deceased *alive on 21-56*, and that death occurred at *1956 pm*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED *2-3-52*

23. BURIAL, Cremation (Removal)	DATE THEREOF <i>21456</i>	NAME OF CEMETERY OR CREMATORIAL <i>SACRED HEART OF MARY</i>	LOCATION (City, town, or county) <i>ERMAN HILL RD</i>	(State)
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <i>John Weber</i>	24. FUNERAL DIRECTOR ADDRESS <i>John Weber 401 S. Chester St</i>		



## 1449 CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

COUNTY BALTO., MD. MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR and give nearest town)  
 TOWN TOWSON 4 LENGTH OF STAY  
 (in this place)  
 30 YRS

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS 6 LINDEN TERRACE

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD. COUNTY BALTO.  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR and give nearest town)  
 TOWNS TOWSON 4  
 STREET ADDRESS (If rural give location)  
 6 Linden Terrace

3. NAME OF  
 DECEASED: (First)

John George

(Middle)

(Last)

## 4. DATE (Month) (Day) (Year)

2 16 1956

## 5. SEX:

M 6. COLOR OR  
 RACE: W 7. SINGLE, MARRIED,  
 WIDOWED, DIVORCED,  
 (Specify):

## 8. DATE OF BIRTH:

July 25, 1873

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.  
 yrs. Months Days Hours Min.

82

10a. USUAL OCCUPATION Give kind of  
 work done during most of working life,  
 even if retired): Accountant10b. KIND OF BUSINESS OR  
 INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

Balto., Md

12. CITIZEN OF WHAT  
 COUNTRY?

## 13. FATHER'S NAME:

Henry J Edel

## 14. MOTHER'S MAIDEN NAME:

EVA AMERIN

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service)

No

## 16. SOCIAL SECURITY NO.:

213-05-8766

## 17. INFORMANT &amp; ADDRESS:

Chas HB Edel (son) 6 Linden Terr  
 Towson 4, Md

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)  
 DUE TO

Coronary occlusion

Interval Between  
 Onset And Death  
 12 hours

## Antecedent causes (s)

Diseases or conditions, if any,  
 giving rise to the above cause  
 stating the underlying cause last, DUE TO

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
 related to the disease or condition causing death.

Acute Pleurisy

1 week

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

None

## 20. AUTOPSY?

Yes  No 21. ACCIDENT  
 SUICIDE  
 HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
 office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
 OF  
 INJURYINJURY OCCURRED  
 While at  
 Work  Not While  
 At Work 

## HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 30, 1947, to Dec 16, 1956, that I last saw the deceased

alive on Feb 17, 1946, and that death occurred at 8:00 A.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION,  
 REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR COLUMBIARY

## LOCATION (City, town, or county)

## (State)

DATE RECD BY LOCAL  
 REGISTRAR

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

J. S. Clifton Jr. 6210 Parkside Baltimore 4-2465-52  
 Dec 18, 1956



## 1450 CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
 OR and give nearest town)  
 TOWN Catonsville (in this place)  
 3 yrs 8 mos 28 days  
 HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS Spring Grove State Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN Baltimore (If rural give location)  
 STREET ADDRESS 1530 John Street

3. NAME OF (First) (Middle) (Last)  
 DECEASED. *Mae Belle Elliott*

4. DATE (Month) (Day) (Year)  
 OF DEATH February 6, 1956

5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, 8. DATE OF BIRTH.  
 Female RACE WIDOWED, DIVORCED. 12-13-1887

9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS.  
 Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Demonstrator

10B. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT COUNTRY?  
 Indiana USA

13. FATHER'S NAME: Vinton F. Merryman

14. MOTHER'S MAIDEN NAME: Alice Dissenbaugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.  
 (Yes, no, or unk.) (If Yes, give war or dates of service) No Unknown

17. INFORMANT & ADDRESS: Records Spring Grove State Hospital

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
 ONSET AND DEATH

*6.3.1*  
 IMMEDIATE CAUSE (A) Rupture of heart

DUE TO

ANTECEDENT CAUSE (B)

Subacute myocardial infarction

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(C) Coronary arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Bilateral hydronephrosis

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
 YES  NO

21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) (County) (State)  
 INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While  Not while   
 at work  at work

21F. HOW DID INJURY OCCUR?

M

22. I hereby certify that I attended the deceased from 7-1953, to 2-5-1956, that I last saw the deceased alive on 2-5-1956, and that death occurred at 9:15PM, from the causes and on the date stated above.

SIGNATURE

*Sueca Wadler*

ADDRESS Spring Grove State Hospital DATE SIGNED

M. D. Catonsville 28, Maryland - 1956

23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county) (State)

Burial

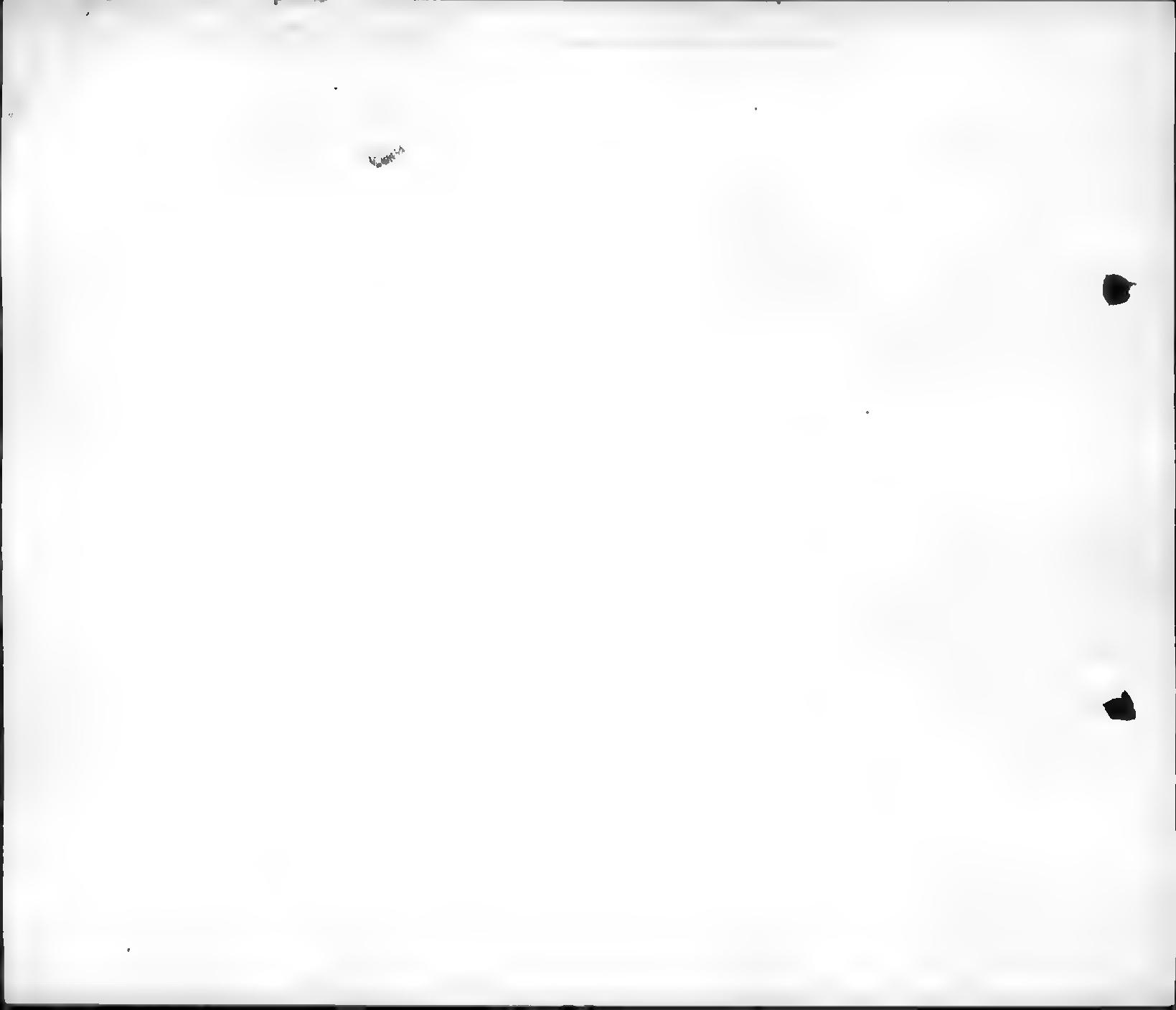
2/9/56

Westminster, Md.

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS

1/1/56 G. C. Hedrick, M. J. Schaefer & Sons - Saenger Ind.







## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01415

## 1452 CERTIFICATE OF DEATH

Reg. Dist. No. 35

## 1. PLACE OF DEATH

COUNTY Baltimore  
 CITY (If outside corporate limits, write RURAL  
 OR and give nearest town)  
 TOWN Parkton

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS Falls Rd.

MARYLAND  
 LENGTH OF STAY  
 (in this place)  
 Life

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md. COUNTY Baltimore  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR TOWN Parkton  
 STREET ADDRESS Falls Rd. (If rural give location)

## 3. NAME OF

(First) (Middle) (Last)  
 (Type or Print) Clifton Tansley Ensor

4. DATE (Month) (Day) (Year)  
 DEATH 2 8 1956

## 5. SEX

Male White

6. COLOR OR  
 RACE

7. SINGLE, MARRIED,  
 WIDOWED, DIVORCED,  
 (Specify) Widower

## 8. DATE OF BIRTH

Feb 22, 1875 80

## 9. AGE last birthday

IF UNDER 1 YEAR  
 Months Days Hours  
 yrs

10a. USUAL OCCUPATION (Give kind of work  
 done during most of working life, even if  
 retired)

Farmer

10b. KIND OF BUSINESS  
 OR INDUSTRY

Farm Owner

## 11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT  
 COUNTRY?

A.S.A.

## 13. FATHER'S NAME

Luke E Ensor

## 14. MOTHER'S MAIDEN NAME

Laura Tansley

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
 (Yes, no, or unk.)

No (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cardiac Failure, Pulmonary Hypostasis.  
 ANTECEDENT CAUSE(S) DUE TO  
 DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE  
 STATING UNDERLYING CAUSE LAST, DUE TO  
 (C) Senility

INTERVAL BETWEEN  
 ONSET AND DEATH

3 day

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.

Chronic Nephritis, Chronic Frostatis. 10 years

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES  NO

21a. ACCIDENT WAS UNDERLYING  
 OR CONTRIBUTING  CAUSE OF DEATH  
 (If either, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory,  
 or INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

## 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
 While at work  Not while  
 at work 

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 6, 1956, to Feb 8, 1956, that I last saw the deceased alive on Feb 6, 1956, and that death occurred at 12 noon, from the causes and on the date stated above.

ADDRESS (Street, city, town, state) DATE SIGNED

Feb 8, 1956

23. BURIAL, CREMATION,  
 REMOVAL (SPECIFY)  
 Burial

## DATE THEREOF

NAME OF CEMETERY OR CREMATORIAL  
 2-11-56 Black Rock Cem.

## LOCATION (City, town, or county)

(State)

Butler Md.

## 24. REC'D BY REGISTRAR

## REGISTRAR'S SIGNATURE

## 25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE 2-11-56

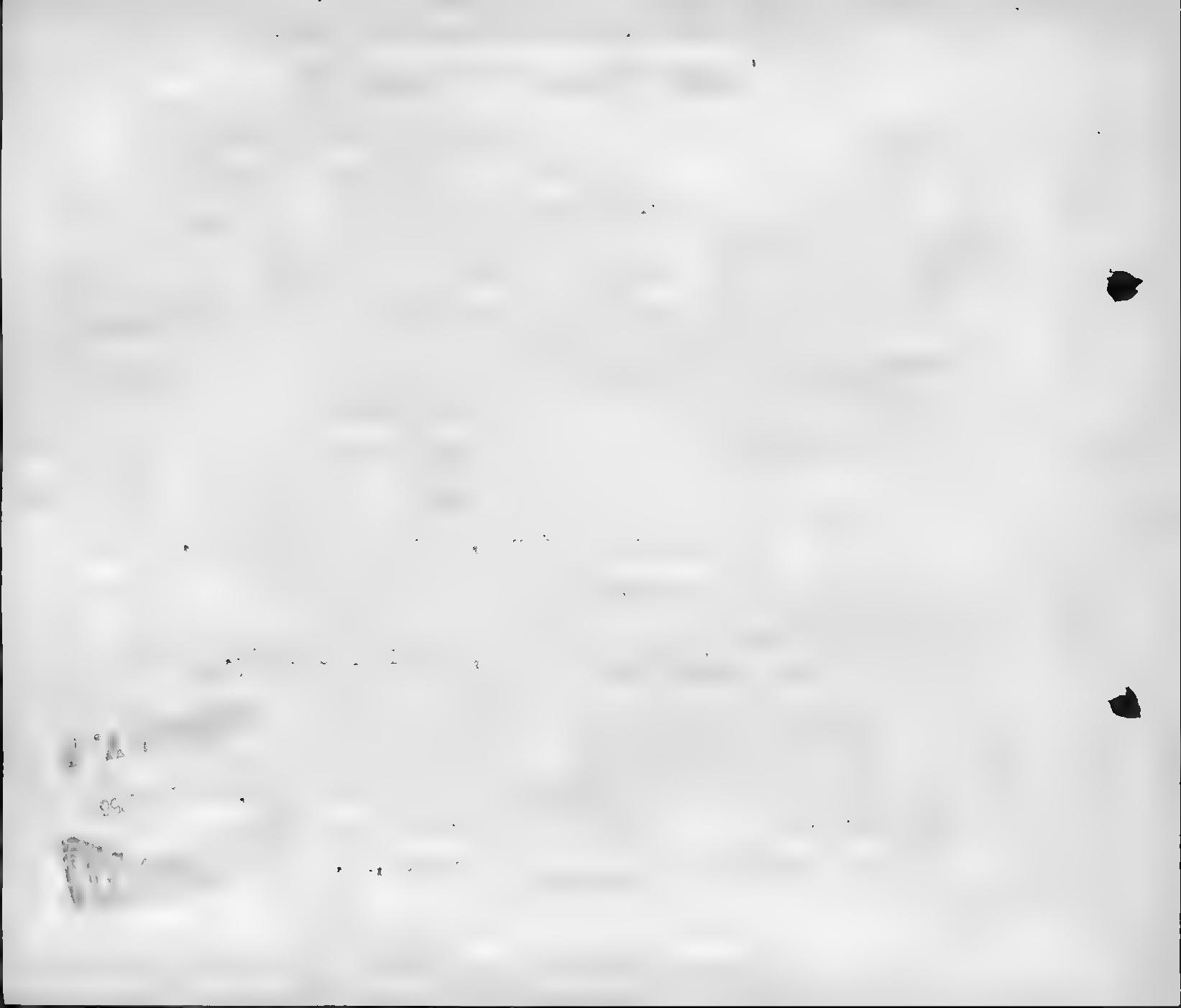
Mrs Howard S. Maitland, L. Scott Brooks, Sparks, Md.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



01416

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1453 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
OR and give nearest town) (in this place)  
TOWN Catonsville 2 yrs. 7 mth. 29 days.

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS SPRING GROVE STATE HOSPITAL

3. NAME OF  
DECEASED:  
(Type or Print) Della

4. DATE (Month) (Day) (Year)  
(First) (Middle) (Last) Ferrell

5. SEX female 6. COLOR OR  
RACE: white 7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify): widow 8. DATE OF BIRTH:  
Oct. 1, ?

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired): housewife

10B. KIND OF BUSINESS  
OR INDUSTRY: --

13. FATHER'S NAME:

John Herbert

15. WAS DECEASED EVER IN U.S. ARMED FORCES  
(Yes, no, or unk.) (If Yes, give war or dates  
of service) unknown

16. SOCIAL SECURITY NO. unknown

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A)  
DUE TO

Cardiac failure with myocardial involvement

ANTECEDENT CAUSE (B)

(B)  
DUE TO

Arteriosclerotic cardiovascular disease

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN  
ONSET AND DEATH

21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory,  
street, office bldg., etc.)

21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
While  Not while   
at work  at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-30, 1955, to 2-28, 1956, that I last saw the deceased  
alive on 2-28, 1956, and that death occurred at 5:03pM, from the causes and on the date stated above.  
SIGNATURE Della W. Waller ADDRESS SPRING GROVE STATE HOSP. DATE SIGNED 2-28-56

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)  
Burial

DATE THEREOF  
3-2-56

NAME OF CEMETERY OR CREMATORIUM  
St John's

LOCATION (City, town, or county)  
Clinton, Md. (State)

DATE REC'D BY LOCAL  
REGISTRAR 3-6-56

REGISTRAR'S SIGNATURE  
E. Barry

24. FUNERAL DIRECTOR

ADDRESS  
The Hunt Funeral Home Waldorf, Md.

BUREAU V. S.

1956

VIDEO

## CERTIFICATE OF DEATH

1454 FOR MEDICAL EXAMINERS

Reg. Dist. No. 32

1. PLACE OF DEATH COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL, and give nearest town) TOWN <i>Baltimore</i>		CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN <i>Baltimore</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Second Mile</i>		STREET ADDRESS <i>sinclair Avenue</i>	
3. NAME OF DECEASED (Type or Print) <i>CHARLES</i>	(First) <i>CHARLES</i>	(Middle) <i>EDWARD</i>	(Last) <i>FIDLER</i>
4. DATE OF DEATH <i>February 3</i>	(Month) <i>Feb</i>	(Day) <i>3</i>	(Year) <i>1956</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>WHITE</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>SINGLE</i>	8. DATE OF BIRTH <i>August 9 1941</i>
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	9. AGE last birthday If under 1 year Months Days Hours <i>14 yrs</i>
10a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>700-10-1000</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHICH COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Charles Edward Fidler</i>	14. MOTHER'S MAIDEN NAME <i>Mildred Anna Staciar</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		17. INFORMANT AND ADDRESS <i>Charles E. Fidler, Jr., 3000 3rd St.</i>	18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>Immediate cause <i>Inhalation of Fire &amp; Generalized</i></p> <p>Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>Complete Body Burns Entire</i></p> <p>(a) <i>Inhalation of Fire &amp; Generalized</i></p> <p>(b) <i>Complete Body Burns Entire</i></p> <p>(c) <i>Clothing on Fire Death by Suffocation</i></p>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <i>INJURY</i>		PLACE (Home, farm, factory, street, office (bldg., etc.)) <i>Home</i>	(CITY OR TOWN) <i>Baltimore</i>
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at work <input type="checkbox"/> No while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <i>in trying to start a fire in iron coal stove in kitchen with which exploded, setting fire to kitchen</i>
22. I certify that I took charge of the remains described above, held an Autopsy, Inspection & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that the deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <i>Leodore F. O'Donnell</i>		(Degree or title) <i>Funeral Director</i>	DATE SIGNED <i>2/3/1956</i>
23. Cremation Date thereof <i>February 6, 1956</i>		NAME OF CEMETERY OR CREMATORIUM <i>Baltimore National Cemetery</i>	LOCATION (City, town, or county) <i>Baltimore</i>
DATE REC'D. BY LOCAL REC'D.		RELATOR'S SIGNATURE <i>Leodore F. O'Donnell</i>	24. FUNERAL DIRECTOR ADDRESS <i>Frank St. Newell, Elmhurst</i>
Feb 5, 1956			

REGISTRATION  
FEB 7 1960

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 21 Form G153 2-24-56 2nd

Medical Examiner

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

PLEASE TYPE OR WHITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The current one is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Baltimore	MARYLAND	STATE Maryland COUNTY Baltimore
CITY (If outside corporate limits, write RURAL or and give nearest town)		CITY, If outside corporate limits, write RURAL and give nearest town)	
TOWN	Fullerton	TOWN	Fullerton
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
Box 494 Fitch Ave.		Box 494 Fitch Ave.	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH: Feb. 9 1956	
William F. Fitch		9. AGE last birthday: 63 yrs IF UNDER 1 YEAR Month Days Hours Min.	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLED. MARRIED WIDOWED, DIVORCED. (Specify): Widowed	8. DATE OF BIRTH: July 19, 1892
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer		10B. KIND OF BUSINESS OR INDUSTRY: Truck Farming	
13. FATHER'S NAME: William Fitch		11. BIRTHPLACE (State or foreign country): Balto. Co. Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME: Elizabeth Hoeb	
17. INFORMANT & ADDRESS: Mrs. Elizabeth Hefner-7723 Belair Rd		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH: 1 minute	
IMMEDIATE CAUSE		A) DUE TO: Generalized Abdominal Cushing	
ANTECEDENT CAUSE (B)		B) DUE TO: Injury - Accidental death	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) Rear of home	
21C. WHERE DID INJURY OCCUR? Fullerton Balto. Md.		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? tractor he was driving to be overtaken drove same into ditch and it overturned on			
22. I hereby certify that I attended the deceased from 2-9-56 to 2-10-56, 1956, that I last saw the deceased alive on 2-10-56 and that death occurred at 8:30 A.M. from the causes and on the date stated above.		ADDRESS DATE SIGNED	
SIGNATURE: Jack C. Collins M.D.		ADDRESS: 21st & Kinsley St. Baltimore Md.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial		NAME OF CEMETERY OR CREMATORIAL St. Joseph's	
DATE THEREOF: 2-13-1956		LOCATION (City, town, or county) Baltimore Md.	
DATE REC'D BY LOCAL REGISTRAR: Feb. 11, 1956		24. FUNERAL DIRECTOR ADDRESS: Mrs. Dr. & Rev. J. & J. Assalim Funeral Home 7401 Belair Rd.	
REGISTRAR			

RECEIVED  
EUREA V. S

FEB 16 1956

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC L-5 10M

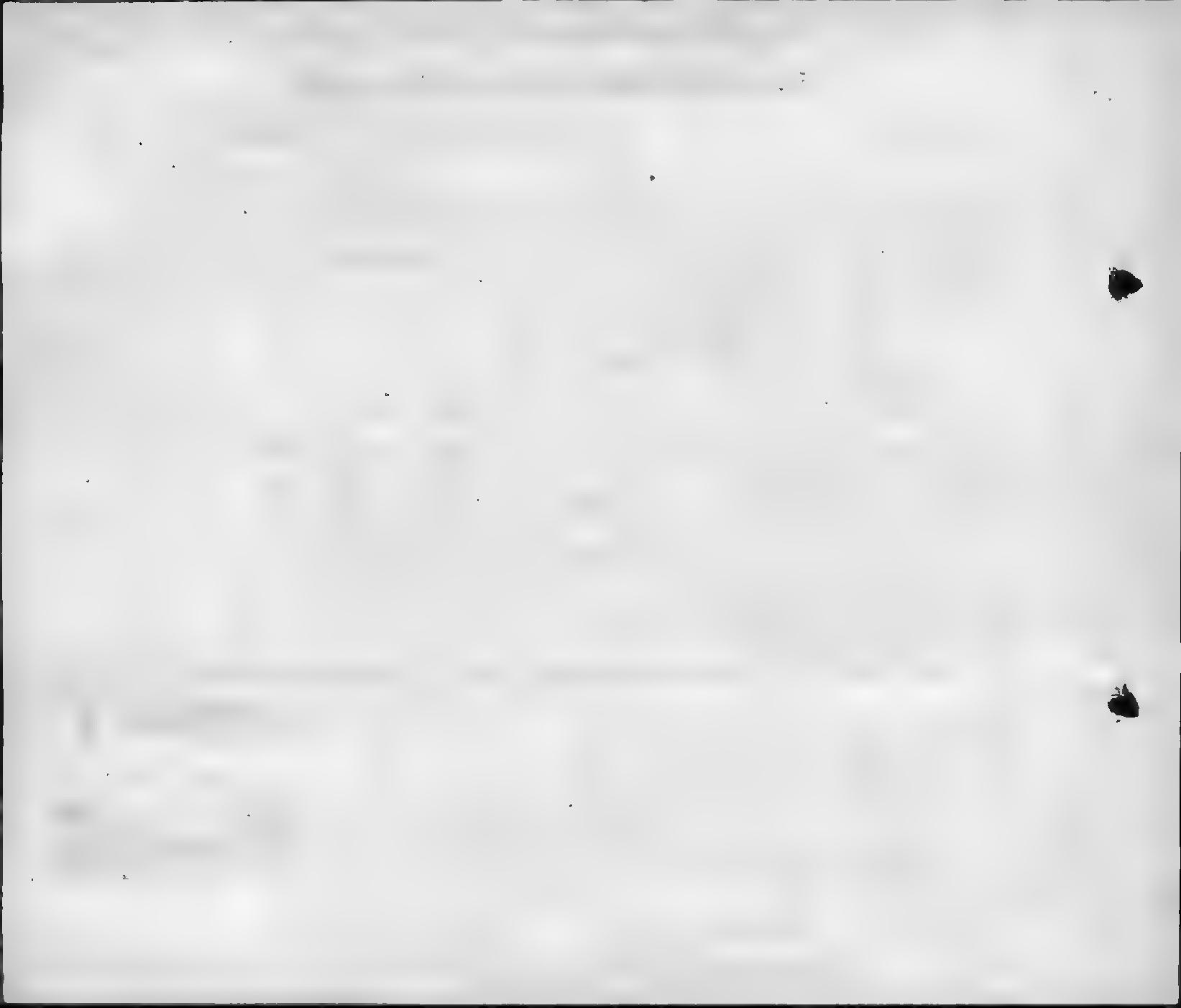
## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01419

## 1456 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED							
COUNTY <b>BALTO</b>		MARYLAND		STATE <b>MD</b>		COUNTY <b>BALTIMORE</b>					
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN <b>PARKVILLE (14)</b>					
TOWN <b>PARKVILLE</b>		4 DAYS		STREET ADDRESS <b>3022 WILLOUGHBY Rd.</b>		(If rural give location) <b>STEWARTSTON N, PA.</b>					
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH							
(First) <b>LOUIS</b> (Middle) <b>HENRY</b> (Last) <b>FITZELL</b>				(Month) <b>2-10-</b> (Day) <b>56</b> (Year)							
5. SEX <b>M</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <b>WEDNESDAY 17 JUNE 1885</b>	9. AGE last birthday <b>70</b>	IF UNDER 1 YEAR Months <b>+</b> Days <b>+</b> Hours <b>+</b> Min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>	11. KIND OF BUSINESS OR INDUSTRY <b>TRUCK FARM</b>	12. BIRTHPLACE (State or foreign country) <b>ALB.</b>	13. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>				11. BIRTHPLACE (State or foreign country) <b>ALB.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>THOMAS R. FITZELL</b>				14. MOTHER'S MAIDEN NAME <b>REBECCA LOHMULLER</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If Yes, give war or dates of service) <b>AL</b>				16. SOCIAL SECURITY NO. <b>213-22-8505</b>				17. INFORMANT & ADDRESS <b>L. MORGAN FITZELL - #1 SEE</b>			
18. MEDICAL CERTIFICATION <b>cerebral Hemorrhage.</b>								INTERVAL BETWEEN ONSET AND DEATH <b>30 hours</b>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH											
IMMEDIATE CAUSE (A)											
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B)											
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)											
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.											
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) <b>BALTIMORE</b> (State) <b>M.D.</b>							
21d. TIME OF INJURY (Month) <b>2-9</b> (Day) <b>1956</b> (Year) <b>1956</b>		21e. INJURY OCCURRED M. While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <b>2-9</b> , 1956, to <b>2-10</b> , 1956, that I last saw the deceased alive on <b>2-10</b> , 1956, and that death occurred at <b>3:40 P.M.</b> from the causes and on the date stated above. SIGNATURE <b>Harold H Burns</b> M.D. <b>8106 Harford Rd.</b> ADDRESS <b>8106 Harford Rd.</b> DATE SIGNED <b>2-10-56</b>											
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		DATE THEREOF <b>2-13-56</b>		NAME OF CEMETERY OR CREMATORIAL <b>CHAK HAIN</b>		LOCATION (City, town, or county) <b>BALTO, C. C. M.D.</b> (State)					
24. REC'D. BY REGISTRAR <b>EEB 1-1956</b>		REGISTRAR'S SIGNATURE <b>Dr. A. M. Bacon</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur Buch Pendley, Mandell, M.D.</b>				ADDRESS			
DATE											



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01420

## 1457 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (In this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY Baltimore
X HOSPITAL OR INSTITUTION OR STREET ADDRESS 2719 Maple Ave.		STREET ADDRESS 3801 W. Harrison Ave.	
3. NAME OF DECEASED (Type or Print) William D. Fleagle		4. DATE OF DEATH Feb 19 1956	
5. SEX M.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH Aug 27 1889 66
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painting Contractor	11. BIRTHPLACE (State or foreign country) Overall Co., Md.
13. FATHER'S NAME Theodore H. Fleagle		14. MOTHER'S MAIDEN NAME Martha O. Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. 218-05-9035	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS Mrs. Erving Lewis 2719 Maple Ave	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) Bronchogenic carcinoma with ANTECEDENT CAUSE(S) DUE TO generalized metastasis DISEASES OR CONDITIONS, IF ANY, (B) giving rise to the above cause STATING UNDERLYING CAUSE LAST. DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M.		21f. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
21g. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb. 1, 1956, to Feb. 19, 1956, that I last saw the deceased alive on Feb. 19, 1956, and that death occurred at 11:38 P.M. from the causes and on the date stated above. SIGNATURE William Fleagle M.D. 8100 Harford Rd., Baltimore, Md. 2-20-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2/19/56	NAME OF CEMETERY OR CREMATORIUM Torrance Park
24. REC'D BY REGISTRAR DATE 1956		REGISTRAR'S SIGNATURE Dr. A. M. Brown	LOCATION (City, town, or county) Baltimore
25. FUNERAL DIRECTOR'S SIGNATURE DATE 1956		ADDRESS Dr. A. M. Brown, Torrance Byers 5005 W. 7th St. Baltimore 15, Md.	



## 1458 CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
 OR and give nearest town) (in this place)  
 TOWN Catonsville 2yrs 9mos 2days

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS Spring Grove State Hospital

3. NAME OF  
 DECEASED:  
 (First) (Middle) (Last)

Lillian F. Foard

4. SEX: 6. COLOR OR  
 RACE: Female White

7. MARRIED,  
 WIDOWED, DIVORCED.  
 (Specify): Widowed

8. DATE OF BIRTH:  
 11-1879

9. AGE last birthday  
 76 yrs.

10. USUAL OCCUPATION (Give kind of  
 work done during most of working life,  
 even if retired) Housewife

10B. KIND OF BUSINESS  
 OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT  
 COUNTRY? USA

## 13. FATHER'S NAME:

John B. Gallaher

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
 (Yes, no, or unk.) (If Yes, give war or dates  
 of service) No

16. SOCIAL SECURITY NO.

Unknown

## 14. MOTHER'S MAIDEN NAME:

Julia E. McAfee

## 17. INFORMANT &amp; ADDRESS:

Records Spring Grove State Hospital

18. MEDICAL CERTIFICATION  
 I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4/22

IMMEDIATE CAUSE

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSE (S)

(B) Generalized arteriosclerosis

DISEASES OR CONDITIONS, IF ANY,  
 GIVING RISE TO THE ABOVE CAUSE  
 STATING UNDERLYING CAUSE LAST.

DUE TO

(C) Senility

INTERVAL BETWEEN  
 ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO

21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
 (If either, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory,  
 OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town)  
 INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
 OF INJURY

21E. INJURY OCCURRED

M. While at work  Not while at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-14-1953 to 2-14-1956, that I last saw the deceased  
 alive on 2-14-1956, and that death occurred at 12:30 P.M. from the causes and on the date stated above.  
 SIGNATURE: Stella Wadley

ADDRESS: Spring Grove State Hospital  
 M. D. Catonsville 28, Maryland DATE SIGNED: 2-11-56

23. BURIAL, CREMATION,  
 REMOVAL (SPECIFY)  
 burial

DATE THEREOF  
 2/17/56

NAME OF CEMETERY OR CREMATORIAL  
 Parkwood Cemetery

LOCATION (City, town, or county) (State)  
 Parkville, Maryland

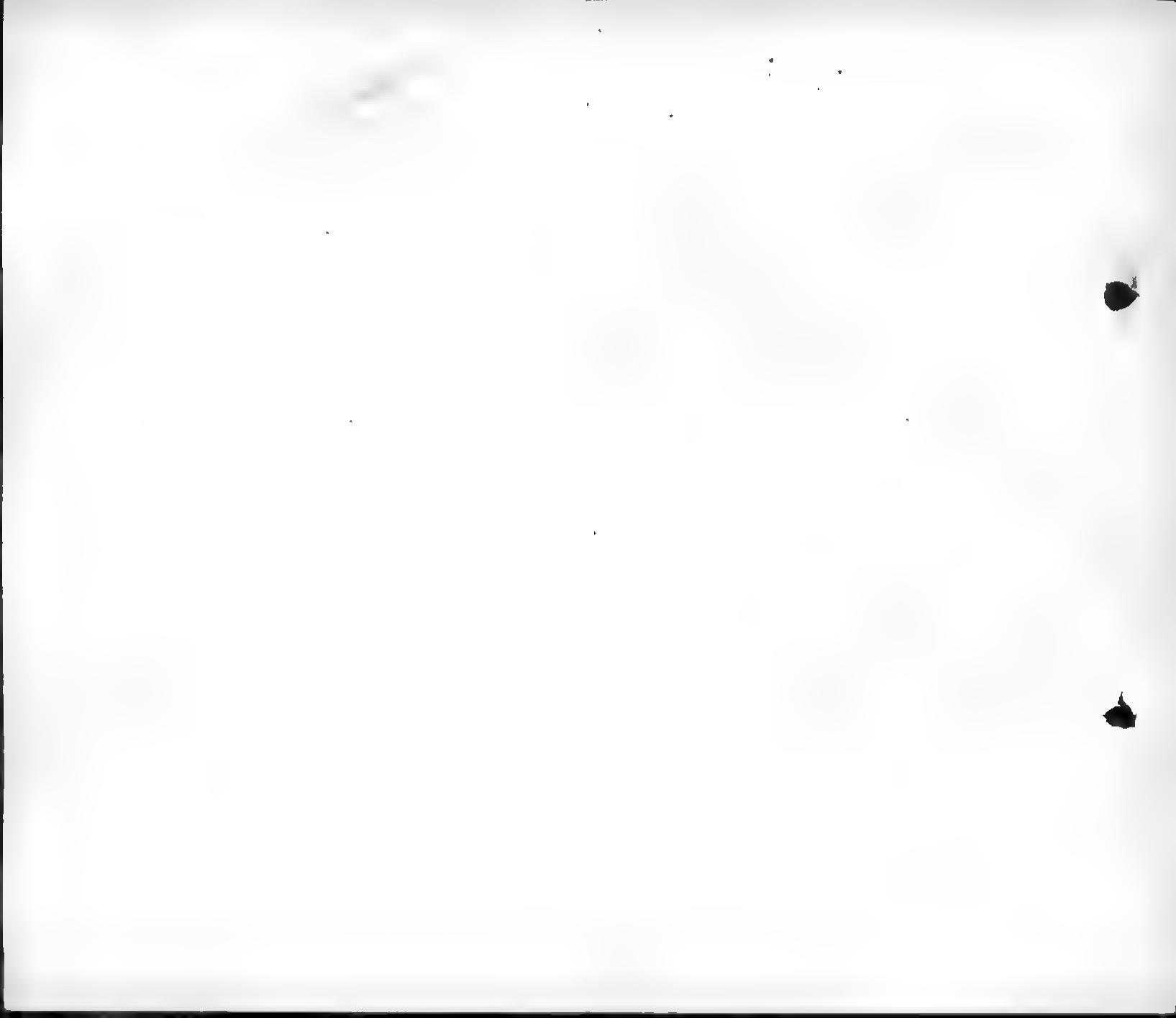
DATE REC'D BY LOCAL  
 REGISTRAR

REGISTRAR'S SIGNATURE

Feb 15, 1956 G. W. Hedrick, Jr., 1217 St. Paul St.

24. FUNERAL DIRECTOR

ADDRESS



01422

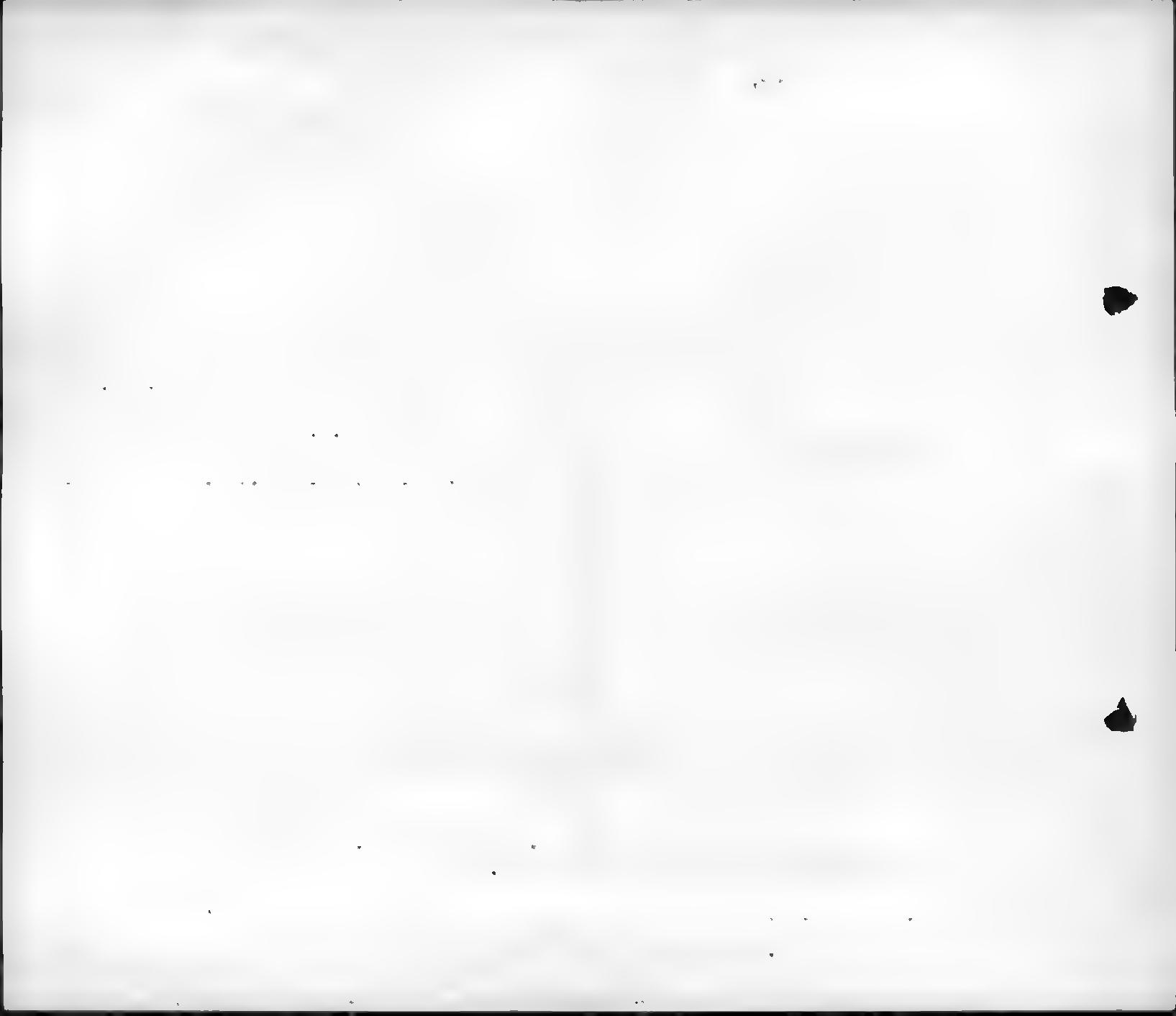
**1459 CERTIFICATE OF DEATH**

Reg. Dist. No. 4

**PLEASE TYPE OR WRITE PLAINLY, WITH UNPADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY		Baltimore MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		ADDRESS	
X TOWN Fort Howard		1 Day		TOWN Baltimore		21	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
Veterans Administration Hospital				4335 Falls Road			
3. NAME OF DECEASED (Type or Print)				4. DATE (Month) (Day) (Year)			
First)		(Middle)		(Last)		OF DEATH February 24 1956	
HARRY		JAMES		FRANK			
5. SEX		6 COLOR OR RACE:		7 SINGLE MARRIED WIDOWED, DIVORCED, (Specify): Married		8 DATE OF BIRTH: 3/16/92	
Male		White				9 AGE last birthday 63 yrs	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY: Senior Investigator B&O Railroad			
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME: Elias Theodore Frank				14. MOTHER'S MAIDEN NAME: Welthy A.A. Thayer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) Yes WW-I				16. SOCIAL SECURITY NO. 705-09-1127			
17. INFORMANT & ADDRESS: Clin. R. C. Vet. Adm. Hosp., Ft. Howard, Md.				18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) CARCINOMA OF PROSTATE WITH METASTASIS				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
ANTECEDENT CAUSE (S) DUE TO TO RIBS AND VERTEBRA							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST				(B) DUE TO			
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
M.		VA		11:30 PM		11:20 AM	
22. I hereby certify that I attended the deceased from Feb. 23, 1956, to Feb. 24, 1956, and that death occurred at 11:20 AM, from the causes and on the date stated above.							
ADDRESS DATE SIGNED							
DONALD D. MARK M.D. M.D. VAH, Fort Howard, Md.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIUM		LOCATION (City, town, or county) (State)	
Burial		Feb. 28, 1956		Baltimore National		Baltimore, Maryland	
DATE REC'D. BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
REGISTRAR		Burke Funeral Home		Burgess Funeral Home		Burke F. Burgess	
REGISTRAR		REGISTRAR'S SIGNATURE		REGISTRAR'S SIGNATURE		REGISTRAR'S SIGNATURE	

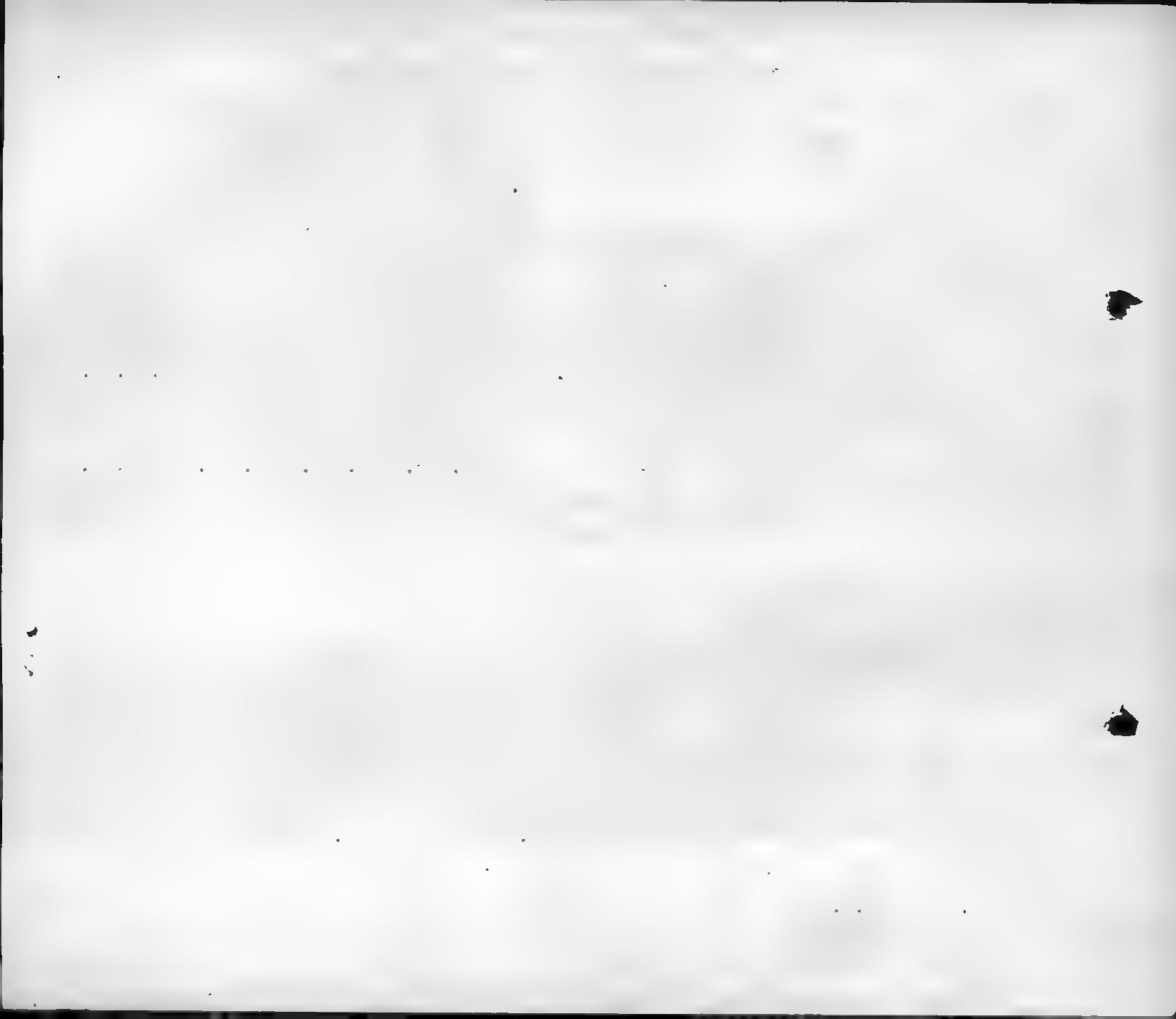


## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01423

## 1460 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town)	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY (If rural give location)
X TOWN Fort Howard	6 Hours 30M.	Baltimore	Maryland 3608 Mary Avenue
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital			
3. NAME OF (First) (Middle) (Last)	4. DATE (Month) (Day) (Year)		
DECEASED (Type or Print) LAWRENCE J. FRANKEL	DEATH: February 29 1956		
5. SEX. Male	6. COLOR OR RACE White	7. SINGLE MARRIED, WIDOWED, DIVORCED. (Specify) Widowed	8. DATE OF BIRTH February 19, 1887 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hat Blocker		10B. KIND OF BUSINESS OR INDUSTRY Mens Hats, Inc.	9. AGE last birthday IF UNDER 1 YEAR Months Days Hours Min.
13. FATHER'S NAME: Rudolph Frankel		11. BIRTHPLACE (State or foreign country): Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If Yes, give war or dates of service WW I		16. SOCIAL SECURITY NO. 214-03-0888	17. INFORMANT & ADDRESS: Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 40-4 IMMEDIATE CAUSE (A) DUE TO LOBAR PNEUMONIA ANTECEDENT CAUSE (B) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? 12:50 PM 6:20 PM	
22. I hereby certify that I attended the deceased from Feb. 29, 1956, to Feb. 29, 1956, that I last saw the deceased alive on <del>February 29, 1956</del> and that death occurred at 6:20 M. from the causes and on the date stated above. SIGNATURE			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		M. D. VAH, FORT HOWARD, MARYLAND 3/1/56 DATE THEREOF NAME OF CEMETERY OR CREMATORIAL LOCATION (If in, town, or county) (State) 3-5-1956 Holy Redeemer Cemetery Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS Jerome Cyach Funeral Home, 900 N. Chester St. Baltimore, Md.	
REGISTRAR'S SIGNATURE			



**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**THE FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained for use as a burial transit permit.

VI ASC-55-10A  
Burial

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01424

## 1461 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Baltimore Fort Howard Veterans Administration Hospital	MARYLAND LENGTH OF STAY (In this place) 8 Days	STATE Maryland COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 5535 Windsor Mill Road, Baltimore STREET ADDRESS (If rural give location) 5535 Windsor Mill Road
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
FRANK F. FULENWIDER		(Month) February 28	(Day) 19 56
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH May 29, 1898
9. AGE last birthday 57 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Payroll Accountant		10b. KIND OF BUSINESS OR INDUSTRY Aircraft	
11. BIRTHPLACE (State or foreign country) Henrietta, North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Fulerwider		14. MOTHER'S MAIDEN NAME Clara Nelson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 212-12-4369	
17. INFORMANT & ADDRESS Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  X IMMEDIATE CAUSE (A) BRONCHIOGENIC CARCINOMA, RIGHT LUNG AND MEDIASTINUM UNKNOWN ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____		19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb. 20, 1956, to Feb. 28, 1956, and that death occurred at 5:45 A.M. from the causes and on the date stated above. SIGNATURE <i>Francis G. DICKEY</i> ADDRESS (Street, city, town, state) DATE SIGNED			
23. BUR. A. CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3-2-56 NAME OF CEMETERY OR CREMATORIAL New Cathedral Cemetery LOCATION (City, town, or county) Baltimore, Maryland (State)	
24. REC'D BY REGISTRAR MAR 5 1956		REGISTRAR'S SIGNATURE Wm. Cook-Bright, Inc. 6009 Harford Rd. Balt. Md.	
25. FUNERAL DIRECTOR'S SIGNATURE			

1000

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01425

## 1462 CERTIFICATE OF DEATH

Reg. Dist. No. 37

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within **24 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained for use as a mail transit permit.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **24 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained for use as a mail transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY STREET ADDRESS
Cockeysville	7 yrs.	Cockeysville, Md.	Maryland
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Baltimore County Home		
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) Mary		(Month) Feb (Day) 11 (Year) 1956	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Feb 11
9. AGE last birthday 60 yrs.	10. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Burton	14. MOTHER'S MAIDEN NAME Nancy T. [illegible]		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.		
(If Yes, give war or dates of service)	17. INFORMANT & ADDRESS Baltimore Co. Home Roads.		
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Coronary Thrombosis			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, (B) giving rise to the above cause STATING UNDERLYING CAUSE LAST. DUE TO			
(C)			
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes mellitus			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 12:30 P.M.	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 1, 1956, to Feb 11, 1956, that I last saw the deceased alive on Feb 11, 1956, and that death occurred at 12:30 P.M. from the causes and on the date stated above. SIGNATURE Elizabeth B. Smith M.D. ADDRESS (Street, city, town, state) Cockeysville, Md. DATE SIGNED 2/11/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF 2/11/56	
24. REC'D BY REGISTRAR DATE 2/11/56		REGISTRAR'S SIGNATURE R. L. Miller	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		F. Scott Brooks, M.D.	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1392

## CERTIFICATE OF DEATH

Reg. Dist. No.

01426

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe, Md.		c. LENGTH OF STAY IN 1b 30	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5704 First Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe, Md.	
3. NAME OF DECEASED (Type or print) George		d. STREET ADDRESS 5704 First Ave.	
4. DATE OF DEATH Feb. 23 1956		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman Retired		10b. KIND OF BUSINESS OR INDUSTRY Coppers Co.	
10c. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gilbert Gillis		14. MOTHER'S MAIDEN NAME Jane Campe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT 212-09-8546 George W. Gillis 5601 Ashbourne Read Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 470+	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Nat wh le at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1926 to Feb. 23, 1956, that I last saw the deceased alive on Feb. 23, 1956, and that death occurred at 12 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Physician's NAME (Type) Howard H. Hubbard		ADDRESS (Street, city or town, state) M.D. 1014 Flowers Ave. - Baltimore, Md. DATE SIGNED Feb. 27, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 27, 1956	
22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park		22d. LOCATION (City, town, or county) Baltimore, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Ave.		24a. REC'D BY REGISTRAR FEB 27 1956	
ADDRESS		24b. REGISTRAR'S SIGNATURE Dr. H. H. Hubbard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

111 (cont'd)

25.1 871

111

## 1463 CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)LENGTH OF STAY  
(In this place)

TOWN Catonsville

3 yrs. 8 mths. 27 days.

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

SPRING GROVE STATE HOSPITAL

3. NAME OF  
DECEASED  
(Type or Print)

(First)

(Middle)

(Last)

female white

SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify):

8. DATE OF BIRTH:

March 9, 1886

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired):10B. KIND OF BUSINESS  
OR INDUSTRY:

seamstress

unknown

11. BIRTHPLACE (State or foreign country):

Maryland, Baltimore

12. CITIZEN OF WHAT  
COUNTRY?  
U.S.A.

## 13. FATHER'S NAME:

Charles E. Handy

## 14. MOTHER'S MAIDEN NAME:

Maggie Eiman Handy

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates  
of service)

unknown

## 16. SOCIAL SECURITY NO.

unknown

## 17. INFORMANT &amp; ADDRESS:

Records of Spring Grove State Hospital

18. MEDICAL CERTIFICATION  
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

43X

## IMMEDIATE CAUSE

(A) Hypertensive cardiovascular disease

INTERVAL BETWEEN  
ONSET AND DEATH

## ANTECEDENT CAUSE (B)

DUE TO

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST

(B)

Arteriosclerotic cardiovascular disease

DUE TO

(C)

Cardiac hypertrophy due to overstrain

DUE TO

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING

Cardiac dilatation due to overstrain

TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES  NO 21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,  
OR INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County) (State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
While  Not while at work  at work 

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1953 to Feb. 28 1956, that I last saw the deceased

alive on Feb. 28, 1956, and that death occurred at 11:40 PM, from the causes and on the date stated above.  
SIGNATURE *Skellie Wachler*

ADDRESS SPRING GROVE STATE HOSP: DATE SIGNED

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL  
REGISTRAR

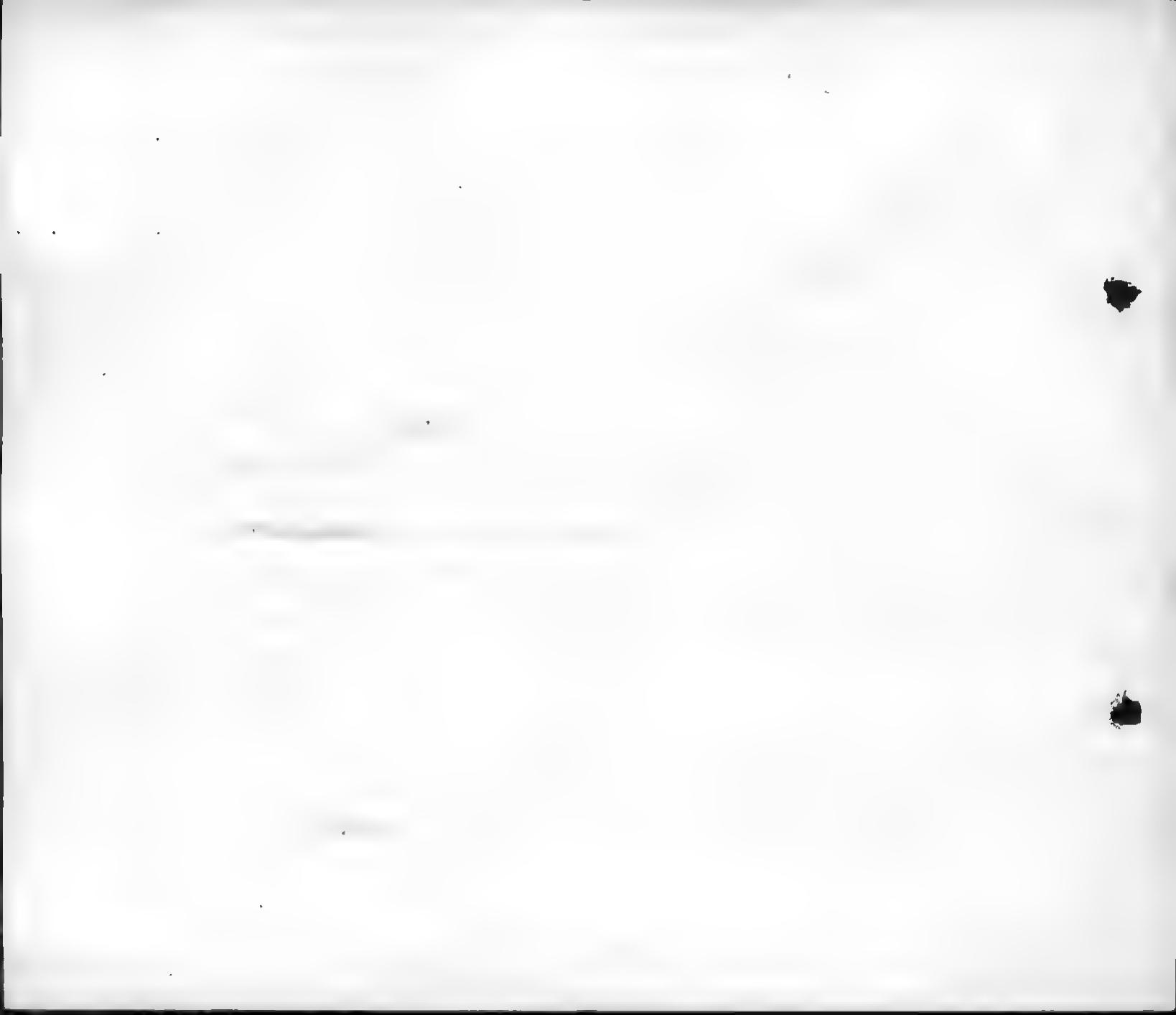
REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.

ADDRESS

2601-3-5 E. Madison St.





11/11/1967

1967

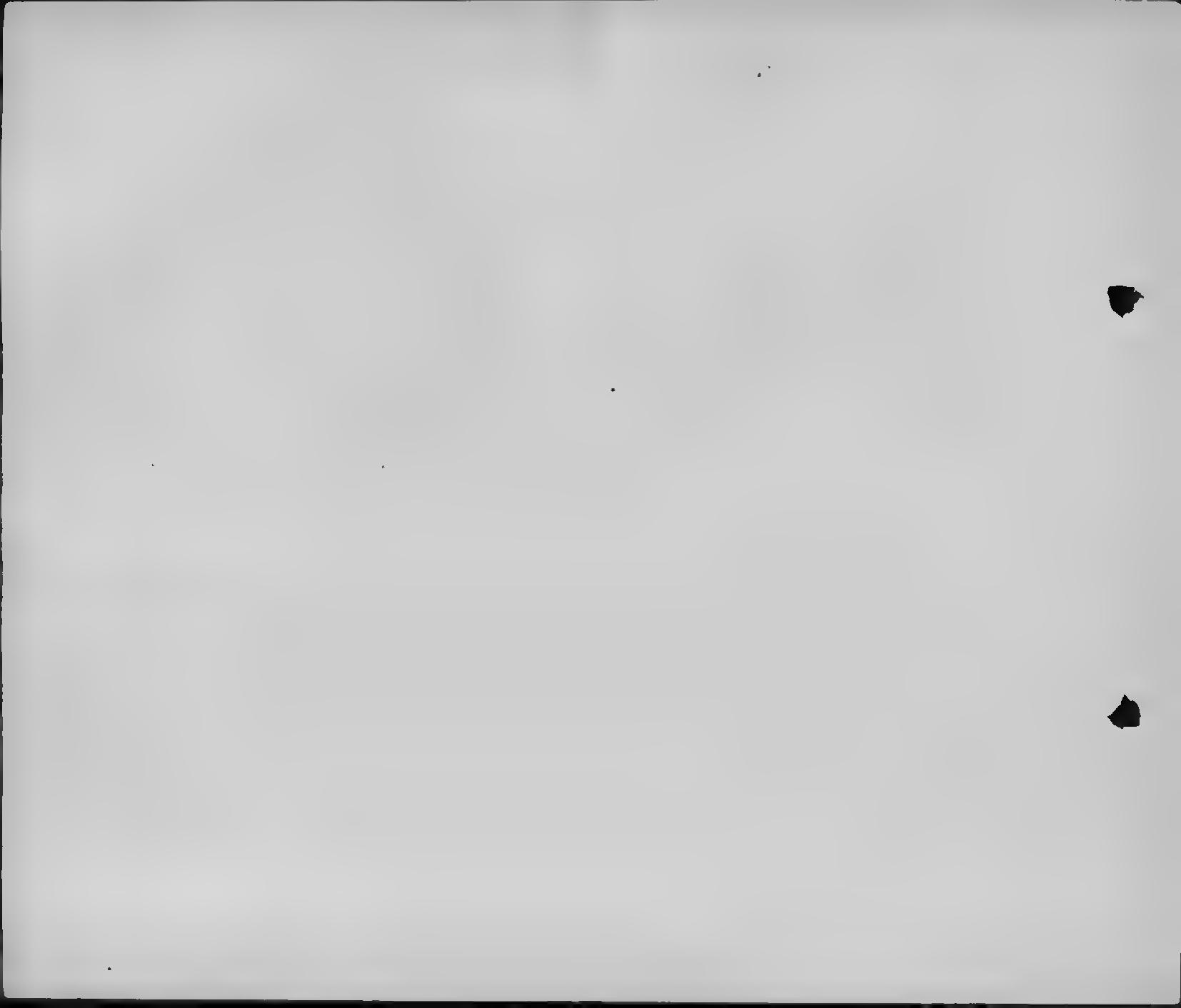
01429

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
1465 FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY		521 Tower Maryland		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	
Towson		8 hrs Daily		STREET ADDRESS 1909 W. North Avenue	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Black & Decker Co. - Jopp Rd.			
3. NAME OF DECEASED (Type or Print)		First)	(Middle)	(Last)	4. DATE OF DEATH 2 17 1956
FRANK		L		GRANGER	(Month) (Day) (Year)
5. SEX		6. COLOR		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	
M		Colored		8. DATE OF BIRTH 12/21/1895	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday 60 yrs.	
Maintenance Man		Tool Mfg.		11. BIRTHPLACE (State or foreign country) Dover, Delaware	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY U.S.A.	
John Windolph		Eva C. Granger			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT AND ADDRESS Margaret G. Valentine 1909 W. North Ave.	
				18. MEDICAL CERTIFICATION Coronary Thrombosis sudden	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH			
44 Immediate cause (a)		Coronary Thrombosis sudden			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)					
(c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy, Inspection & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> SIGNATURE (Degree or title) ADDRESS DATE SIGNED					
Cremation DATE (MoP) (Local Cemetery)		NAME OF CEMETERY OR CEMATORIUM Whatcoat - Silver Lake Dr.		LOCATION (City, town, or county) (State) Dover, Delaware	
Burial DATE (MoP)					
DATE KEPT BY LOCAL REG. MARS SIGNATURE		24. FUNERAL DIRECTOR Charles R. Law		ADDRESS 802 Madison Ave.	

MARGIN RESERVED FOR BINDING  
ARE TO BE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## 1466 CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

COUNTY **BALTIMORE** MARYLAND  
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
 OR and give nearest town) (in this place)  
 TOWN **CATONSVILLE** 5 WKS.  
 HOSPITAL OR  
 INSTITUTION OR **HOUSE IN THE PINES**  
 STREET ADDRESS **NURSING HOME.**

3. NAME OF (First) (Middle) (Last)

4. DATE (Month) (Day) (Year)

5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, 8. DATE OF BIRTH:

RACE: WIDOWED, DIVORCED, (Specify)

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): **BALTIMORE, MD.**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

**John HERMAN GRESS.**

14. MOTHER'S MAIDEN NAME:

**UNKNOWN**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. **NO.**

## 17. INFORMANT &amp; ADDRESS:

18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A) DUE TO **Broncho-Pneumonia**

INTERVAL BETWEEN  
ONSET AND DEATH

**10 da.**

ANTECEDENT CAUSE (S)

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C)

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

**Chronic Hypertension Cardio-Vascular Disease**

**10/21/56**

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO

21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or Town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While  Not while

M. at work  at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **1-20**, 1956, to **2-16**, 1956, that I last saw the deceased

alive on **2-16**, 1956, and that death occurred at **2:47 P.M.** from the causes and on the date stated above.

SIGNATURE

*Elmer K. Jollager*

ADDRESS

DATE SIGNED

**M.D. Catonsville-28, Md. 2-18-56**

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county) (State)

**BURIAL**

2-20-56. SACRED HEART CEM.

7401 GERMAN HILL RD., MD.

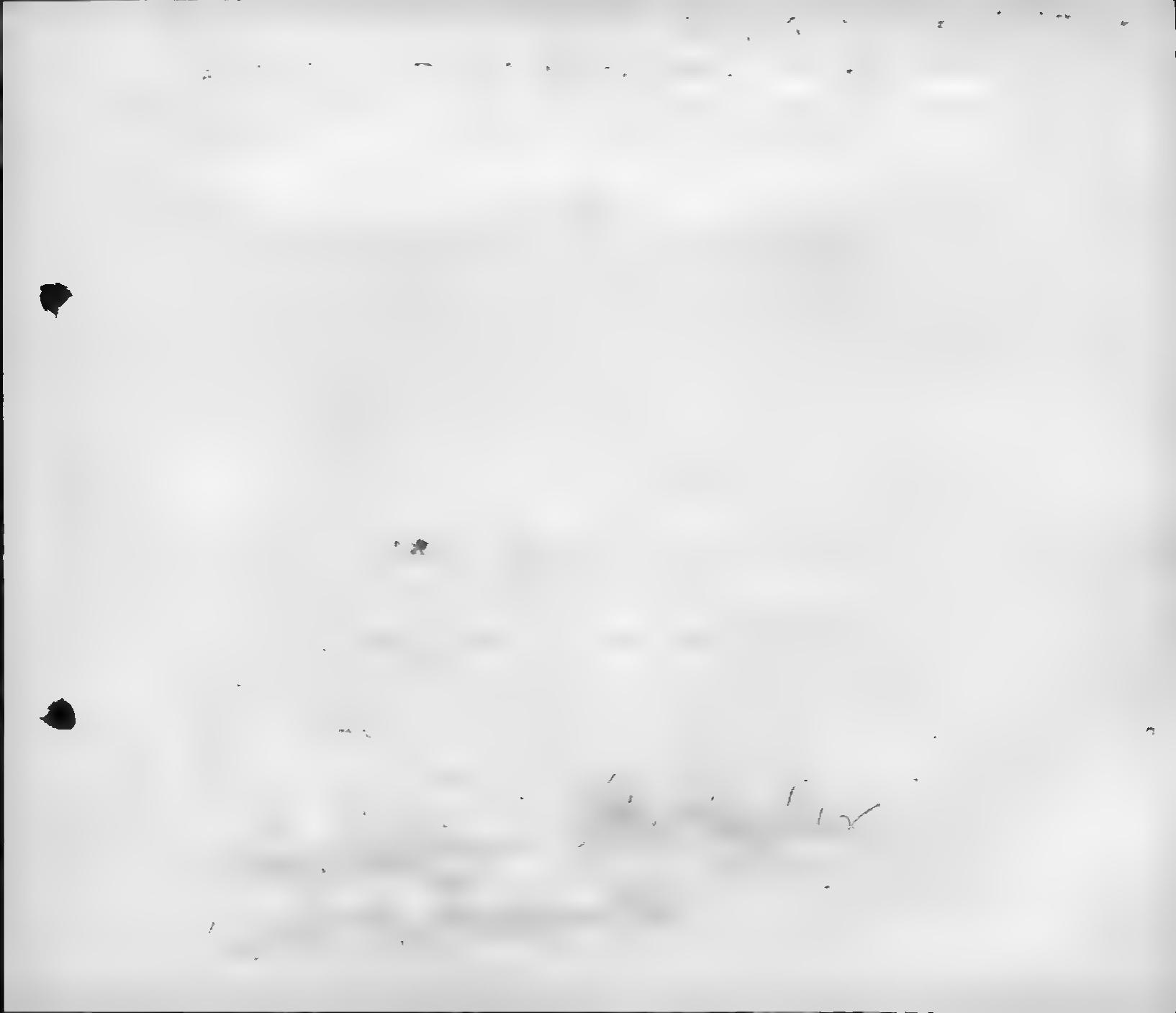
DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

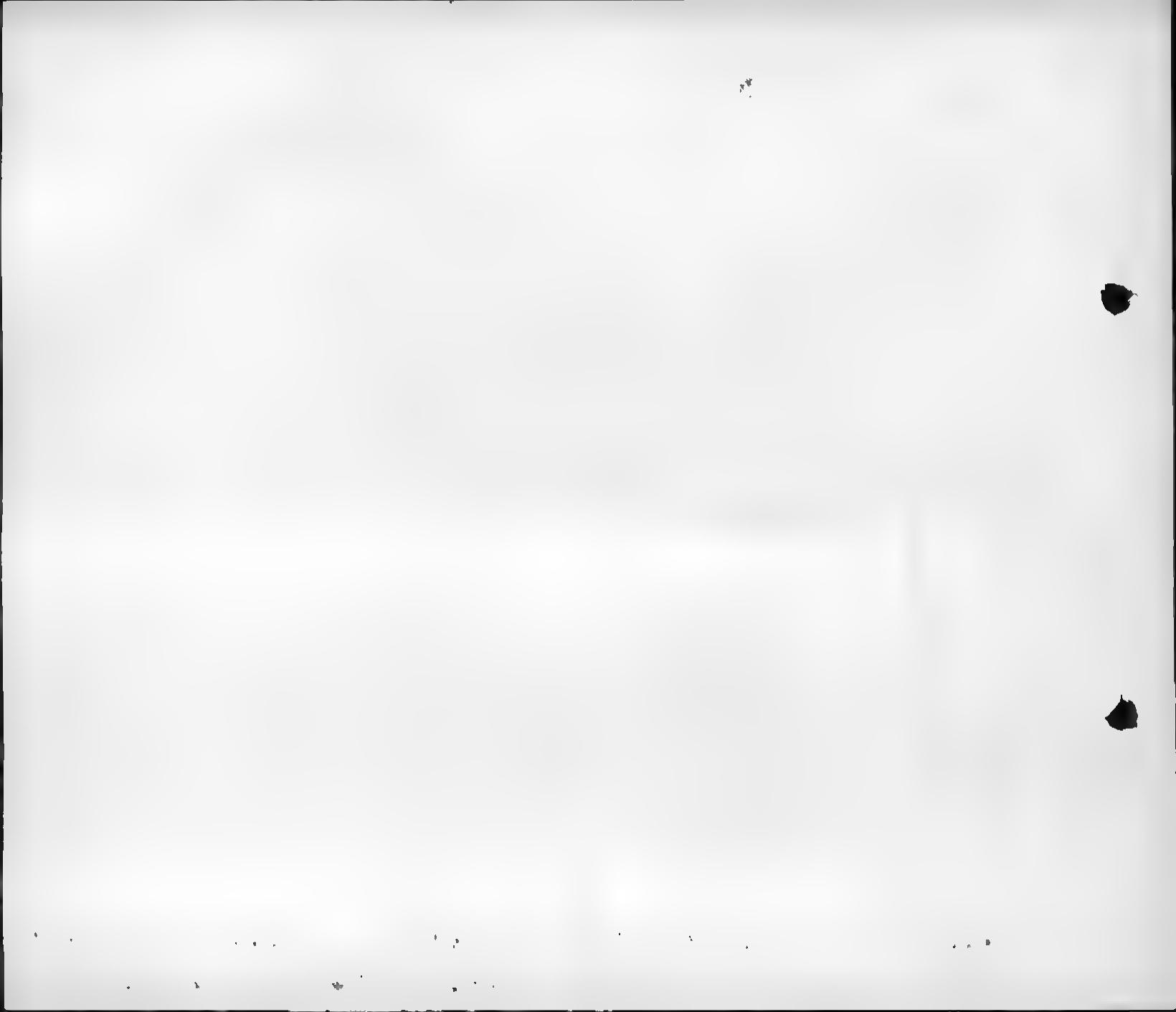
24. FUNERAL DIRECTOR

ADDRESS

**Charles J. Seiter 901 S. CONKLING ST. BALTO., MD.**







MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE. 18

01432

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital		STREET (If rural give location) ADDRESS County Home	
3. NAME OF DECEASED: (Type or Print)	(First) Sally	(Middle) Franklin	(Last) Hall
4. DATE OF DEATH: February 23, 19 56	(Month)	(Day)	(Year)
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed	8. DATE OF BIRTH: 10-1-1879
9. AGE last birthday: 76 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: R. T. Connor	14. MOTHER'S MAIDEN NAME: Elizabeth Franklin		
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT & ADDRESS: Records Spring Grove State Hospital	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE	(A) Generalized arteriosclerosis		
ANTECEDENT CAUSE (B)	DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8-23-19 55 to 2-23-19 56, that I last saw the deceased alive on 2-23-19 56, and that death occurred at 10:45A, from the causes and on the date stated above. SIGNATURE S. Wachler ADDRESS DATE SIGNED Sprigg Grove State Hospital M. D.			
23. BURIAL, CREMATION, REMOVAL (SPECIAL) Burial in ground	DATE THEREOF 2/24/56	NAME OF CEMETERY Catawba	289 Maryland town, or 2023-56 (State)
DATE REC'D. BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE C. A. H.	24. FUNERAL DIRECTOR	ADDRESS

BUCKEY J. B.

FEB 2

6252

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01433

1385

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

Item 7, 6, 7, Film G192 2 1/4 50 ft

## 1. PLACE OF DEATH

COUNTY BALTIMORE

MARYLAND

CITY (If outside corporate limits, write RURAL and  
OR give nearest town)

TOWN DUNDALK

LENGTH OF STAY  
(in this place)  
20 YEARSHOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

225 MAPLE AVE

3. NAME OF  
DECEASED  
(Type or Print)

WOODIE

(First) ROBERT

2. USUAL RESIDENCE (HOME) OF DECEASED  
STATE MARYLAND

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR  
TOWN DUNDALK MDSTREET  
ADDRESS  
(If rural, give location)

225 MAPLE AVE.

4. DATE  
OF  
DEATH

2 - 4 1956

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED  
(Specify)

Married

8. DATE OF BIRTH

5-26-1896

9. AGE last birthday

59 yrs.

If under 1 year  
MonthsIf under 24 hrs.  
DaysIf under 24 hrs.  
Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

FARMER

10b. KIND OF BUSINESS OR  
INDUSTRY

BETHLEHEM STEEL

11. BIRTHPLACE (State or foreign country)

ALBEMARLE COUNTY

12. CITIZEN OF WHAT  
COUNTRY

U.S.A

13. FATHER'S NAME

JOHN HALL

14. MOTHER'S MAIDEN NAME

PEARL WOOD

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of  
service)

No

16. SOCIAL SECURITY NO.

718-10-6505

17. INFORMANT AND ADDRESS

PEARL HALL 225 MAPLE AVE. 22

18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

Immediate cause

(a) --

Coronary occlusion

6 week

Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last

(b) --

Arteriosclerotic Heart Disease

4 yrs

(c) --

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)

OF  
INJURYINJURY OCCURRED  
While at Work  Not While At work 

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 1, 1955, to Feb 4, 1956, that I last saw the deceased

alive on Feb 1, 1956, and that death occurred at 7 a.m., from the causes and on the date stated above.  
SIGNATURE (Degree or title) ADDRESS DATE SIGNED  
E. R. Evans M.D. 1 Liberty Highway Feb 4, 195623. BURIAL, CREMATION  
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county) (State)

PRIZE HILL CEMETERY VA

BUNNIESVILLE VIRGINIA

DATE REC'D BY LOCAL REG.

REG. DATE REC'D BY LOCAL REG.

24. FUNERAL DIRECTOR

ADDRESS

Walter J. Kelly Jr. &amp; Son

Ball 3-4 ml

The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

CEMADU V. 3

1975

## 1469 · CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

COUNTY Baltimore 19 MARYLAND  
 CITY (If outside corporate limits, write RURAL  
 OR and give nearest town) LENGTH OF STAY  
 TOWN St. Marrows 3+ (in this place) 63 yrs.  
 HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS 710 E. St.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE as COUNTY  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN su (If rural, give location)  
 STREET  
 ADDRESS # 1.

## 3. NAME OF (First) (Middle) (Last)

DECEASED: (Type or Print) ANTON. A. HALVORSEN.

## 4. DATE (Month) (Day) (Year)

OF DEATH: FEB. 7. 1956.

## 5. SEX:

6. COLOR OR RACE: male - white 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married 8. DATE OF BIRTH: Jan 10. 18629. AGE last birthday: 94 yrs. IF UNDER 1 YEAR  
 Months 0 Days 0 Hours 0 Min. 0

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: trigger - steel mill 11. BIRTHPLACE (State or foreign country): Norway 12. CITIZEN OF WHAT COUNTRY? U.S.A.

## 13. FATHER'S NAME:

Unknown

## 14. MOTHER'S MAIDEN NAME:

Unknown

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No16. SOCIAL SECURITY NO.: 212-16-0655 17. INFORMANT & ADDRESS: Lillian Halvorsen address as in # 1.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

449X  
Immediate cause

(a) DUE TO

Cerebral Hemorrhage + hemiplegia 2 days ago

Antecedent cause(s)

(b) DUE TO

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c)

Hypertensive cardiovascular disease 10 yrs.  
atherosclerosis 20 yrs.

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

prior cerebral hemorrhage + hemiplegia 18 mo.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

## 20. AUTOPSY?

Yes  No 

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, of office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE				
HOMICIDE				

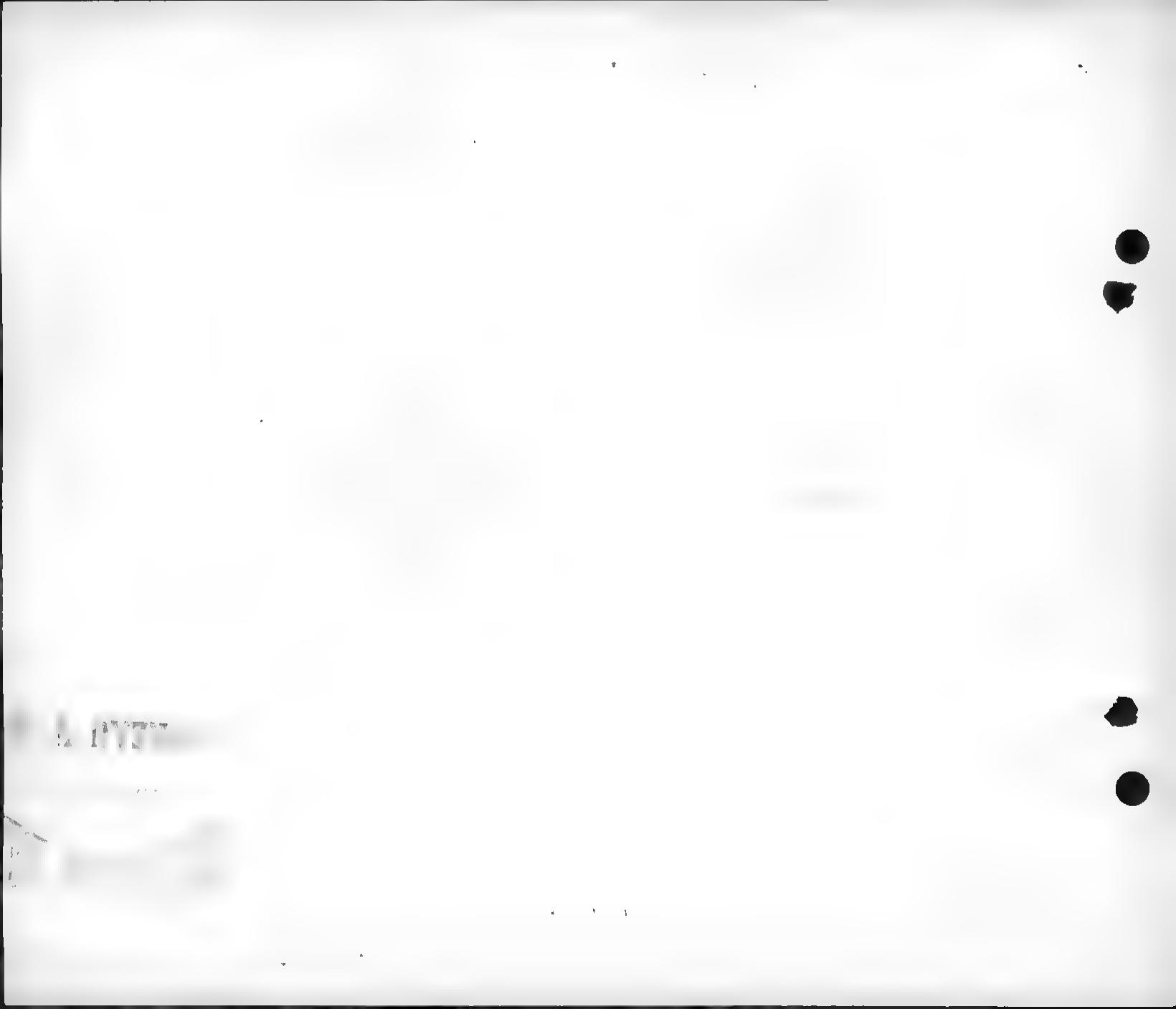
TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED	HOW DID INJURY OCCUR?
OF				While at work <input type="checkbox"/>	Not while at work <input type="checkbox"/>
INJURY				M.	

22. I hereby certify that I attended the deceased from Dec 22, 1955 to Feb. 7., 1956 that I last saw the deceased alive on Feb. 7., 1956, and that death occurred at 8:30 P.M. from the causes and on the date stated above.

SIGNATURE James N. Hollie, M.D. DEGREE OR TITLE ADDRESS DATE SIGNED 2/7/56.

23. BURIAL, CREMATION REMOVAL (Specify): <u>BURIAL</u>	DATE THEREOF: <u>2-10-56</u>	NAME OF CEMETERY OR CREMATORIAL: <u>MORELAND MEM. PARK</u>	LOCATION (City, town, or county) (State): <u>BALTO. CO., Md.</u>
--	------------------------------	--	--

DATE REC'D BY LOCAL REG. OFF.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Feb. 9, 1956</u>	<u>Dawson L. Larkey</u>	<u>Walter Burke, Funeral, Md.</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56 et

01435

1470

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN Catonsville

LENGTH OF STAY  
(in this place)

2mths. 21 days

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

STRINGGROVE STATE HOSF.

3. NAME OF  
DECEASED:  
(Type or Print)

(First)

(Middle)

(Last)

Lillye

A

Hamilton

## 4. SEX:

female

5. COLOR OR  
RACE:

white

6. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify)

widowed

## 7. 8. DATE OF BIRTH:

1-29-1896 1881

1-29-1896 1881

## 9. AGE last birthday

75

70 yrs.

## 10. IF UNDER 1 YEAR

Months

Days

## 11. IF UNDER 24 HRS.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired):

Housekeeper

House

10B. KIND OF BUSINESS  
OR INDUSTRY:

Homes

## 11. BIRTHPLACE (State or foreign country):

Maryland

12. CITIZEN OF WHAT  
COUNTRY?

USA

## 13. FATHER'S NAME:

John

A. Frank P. L.

14. WAS DECEASED EVER IN U.S. ARMED FORCES  
(Yes, no, or unk.) (If Yes, give war or dates  
of service)

unknown

## 15. SOCIAL SECURITY NO.

unknown

## 16. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

## IMMEDIATE CAUSE

(A) Hypertensive arteriosclerotic heart disease

## ANTECEDENT CAUSE (S)

## DUE TO

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(B) General arteriosclerosis, hypertension

## DUE TO

(C) Diabetes, obesity

## DUE TO

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES  NO 21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

## 21E. INJURY OCCURRED

While  Not while at work  at work 

## 21F. HOW DID INJURY OCCUR?

M.  at work  at work 

## 22. I hereby certify that I attended the deceased from July 19 53 to Feb. 9, 1956, that I last saw the deceased

alive on Feb. 9, 1956, and that death occurred at 12:00 M, from the causes and on the date stated above.

## SIGNATURE

A. Lynne Williams

## ADDRESS

## DATE SIGNED

SPRING GROVE STATE HOSP.

2/2/56

M. D. Catonsville 28 Md.

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORIUM

## LOCATION (City, town, or county)

(State)

Burial

3-11-56

MCRELAND Memorial

Baltimore

Md

DATE REC'D BY LOCAL  
REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

Feb. 10, 1956 A. L. Hedrick &amp; Son 5803 Harford Rd.



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct and especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

01436

1471 CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 43

1. PLACE OF DEATH:  
COUNTY

Balti

MARYLAND

CITY (If outside corporate limits, write RURAL and  
OR give nearest town)LENGTH OF STAY  
(in this place)HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Overleg

5 Councilman Ave

3. NAME OF  
DECEASED  
(Type or Print)

Martha

H.

Hanson

(Last)

## 4. SEX

F.

## 6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED  
(Specify)

Widowed

## 8. DATE OF BIRTH

Jan 6 1890

## 9. AGE last birthday

66

yr.

If under 1 year  
Months

Days

If under 24 hrs.  
Hours

Mins.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

At home

10b. KIND OF BUSINESS OR  
INDUSTRY

At Home

## 11. BIRTHPLACE (State or foreign country)

Menomonie Wis.

12. CITIZEN OF WHAT  
COUNTRY?

U.S.A.

## 13. FATHER'S NAME

August

Katt

## 14. MOTHER'S MAIDEN NAME

Henetta

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of  
service)

No

## 16. SOCIAL SECURITY NO.

None

## 17. INFORMANT AND ADDRESS

Herbert A. Hanson 5 Councilman

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

51X  
Immediate cause

(a) Cerebral Hemorrhage

INTERVAL BETWEEN  
ONSET AND DEATH

5 hrs.

## Antecedent cause(s)

Diseases or conditions, if any, (b)  
giving rise to the above cause  
stating the underlying cause last

(c)

2. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. EXTERNAL CAUSE WAS  
PRIMARY OR CONTRIBUTING  
CAUSE OF DEATH.PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF  
INJURYINJURY OCCURRED  
While at work  Not while  
at work 

## HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes  accident  suicide  homicide  undetermined

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Jack Colleens Dept. Med. Ex. Balt 22  
23. FUNERAL, CREMATION OR  
REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)BURIAL FEB 20 1956 PEACE LUTHERAN CEM. MENOMONIE WISCONSIN  
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS

Feb 16, 1956 C. W. Herberg, Coffel Bros. 110 Belair Rd.



## 1472 CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
 OR and give nearest town) (in this place)  
 TOWN Fort Howard 15 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN Baltimore (If rural give location)

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS Veterans Administration Hospital

7236 Sollers Point Road

3. NAME OF DECEASED. (First) (Middle) (Last)  
 (Type or Print) WILLIAM (MM) HARPER

4. DATE (Month) (Day) (Year)  
 OF DEATH February 10 1956

5. SEX: 6. COLOR OR RACE: 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): 8. DATE OF BIRTH: 9. AGE last birthday  
 Male White Married 11/3/98 57

IF UNDER 1 YEAR  
 Months Days Hours Min.  
 yrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY:  
 Machinist Machine Shop

11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT COUNTRY?  
 Everson, Pa. U.S.A.

## 13. FATHER'S NAME:

John E. Harper

## 14. MOTHER'S MAIDEN NAME:

Mary O'Donahue

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.  
 (Yes, no, or unk.) (If Yes, give war or dates of service) Yes 218-28-0739

## 17. INFORMANT &amp; ADDRESS:

Clin. Red., Vet. Adm. Hosp., Ft. Howard, Md.

18. MEDICAL CERTIFICATION  
 I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## IMMEDIATE CAUSE

(A) ARTERIOSCLEROTIC HEART DISEASE

INTERVAL BETWEEN  
 ONSET AND DEATH

## ANTECEDENT CAUSE (S)

DUE TO

UNKNOWN

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE  
 STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
 YES  NO 

21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
 (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County) (State)

21D. TIME (Month) (Day) (Year) (Hour)  
 OF INJURY21E. INJURY OCCURRED  
 While  Not while   
 at work  at work 

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January 26 1956, to February 10 1956, that I last saw the deceased  
 alive on ~~January 26 1956~~, and that death occurred at 9:05PM, from the causes and on the date stated above.  
 SIGNATURE *John J. Kennedy* ADDRESS DATE SIGNED  
 JOHN J. KENNEDY, M.D. M.D. VAH, Fort Howard, Md. 2/10/56

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF  
 2-14-56NAME OF CEMETERY OR CREMATORIAL  
 Sacred Heart CemeteryLOCATION (City, town, or county) (State)  
 Baltimore, Maryland

DATE NEED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE  
 Rev. Dawson L. Farley

ATTORNEY DIRECTOR  
 Walter Brooks Bradley  
 700 Willow Spring Rd., Balt. 22, Md.

PEREAU N.Y.

FEB 16 1950

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155-10A

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18****CERTIFICATE OF DEATH**

1473

01438

39

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY	Baltimore	STATE	Md
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)	MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town)	Baltimore
MURKIN	LENGTH OF STAY (in this place)	TOWN	Snoultor
MURKIN RD	8 yrs	STREET ADDRESS	(If rural give location) MURKIN RD
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE</b> (Month) (Day) (Year) OF DEATH	
(First)	(Middle)	(Last)	February 24 1956
Male	Grayson	Harris	
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>
	Colored	MARRIED Sept 22 1883	72
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (State or foreign country)
Farmer		Re tired	Maryland - Balt Co
<b>13. FATHER'S NAME</b>		<b>14. MOTHER'S MAIDEN NAME</b>	
George Henry Harris		Eliza Cromwell	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS	
		wife - Estella V. Harris MURKIN RD	
<b>18. MEDICAL CERTIFICATION</b>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Arterio sclerotic cardio-vascular disease over 8 yrs			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, (B) _____			
GIVING RISE TO THE ABOVE CAUSE DUE TO			
STATING UNDERLYING CAUSE LAST. DUE TO (C) _____			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from February 1956 to February 1956, that I last saw the deceased alive on 24 Feb 1956, and that death occurred at 11 A.M. from the causes and on the date stated above. SIGNATURE Hector T. Keas			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb 28-56	
24. REC'D BY REGISTRAR MAR		NAME OF CEMETERY OR CREMATORIUM Fairview colored	
DATE		LOCATION (City, town, or county) Forest Hill, Md	
REGISTRAR'S SIGNATURE Mrs. Ely. Gorench		25. FUNERAL DIRECTOR'S SIGNATURE Morton E. Keas	
ADDRESS		ADDRESS	

200 V  
MR  
DECEMBER 2000

## MARYLAND STATE DEPARTMENT OF HEALTH

01439

CERTIFICATE OF DEATH  
1474 FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH COUNTY CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		2. USUAL RESIDENCE (HOME) OF DECEASED STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS	
Baltimore Maryland Baltimore Cliver Beach		Md. Cliver Beach Rt. 14 Box 112	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
George Bowen Hauf		2-17 1856	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, SOME	8. DATE OF BIRTH 3-16-1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		9. AGE last birthday 62 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY Builder		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME George Albert Hauf.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Florence Hauf (Same)		18. MEDICAL CERTIFICATION	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary disease  
 Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause  
 stating the underlying cause last  
 (c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing in the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> OF CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) OF INJURY	(Day) Year m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes  accident  suicide  homicide  undetermined .

SIGNATURE (Degree or title) ADDRESS

DATE SIGNED 2/18/56

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF 2-21-56	NAME OF CEMETERY OR CREMATORIAL Balto. National	LOCATION (City, town, or county) Balto	(State) Md.
DATE REC'D BY LOCAL REC'D Feb 20 1956	REGISTRAR'S SIGNATURE A.W. Hirsch	24. FUNERAL DIRECTOR ADDRESS John J. Connelly Esq. Md.		



## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01440

38

## 1475 CERTIFICATE OF DEATH

Reg. Dist. No.....

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155-10A

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Parkville		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parkville		(If rural give location) STREET ADDRESS 8117 Bon Air Road	
HOSPITAL INSTITUTION OR STREET ADDRESS 8117 Bon Air Road				8. DATE OF BIRTH 9. AGE last birthday 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home			
5. SEX female		6. COLOR OR RACE white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		11. BIRTHPLACE (State or foreign country) Clearfield County, Penna	
10a. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME John Smith				14. MOTHER'S MAIDEN NAME Jennie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Thelma Gail Brungard, 8117 Bon Air			
18. MEDICAL CERTIFICATION <i>Myocarditis c. degeneration Coronary Thrombosis Atherosclerosis</i>							
INTERVAL BETWEEN ONSET AND DEATH 6 mos.							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
IMMEDIATE CAUSE (A)		ANTECEDENT CAUSE(S) DUE TO (B)		DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)		DUE TO (D)	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		(State)	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) <i>Aug 1955 to Sept 1956</i>		(County)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Aug 1955 to Sept 1956</i> , that I last saw the deceased alive on <i>Feb 14 1956</i> , and that death occurred at <i>9:15 P.M.</i> from the causes and on the date stated above. SIGNATURE <i>Frank J. Larik</i> M.D. ADDRESS (Street, city, town, state) <i>9005 Harford Rd</i> DATE SIGNED <i>2/16/56</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 18, 1956		NAME OF CEMETERY OR CREMATORIUM Hill Crest Cemetery		LOCATION (City, town, or county) Clearfield, Penna.	
24. REC'D BY REGISTRAR <i>John M. Beale</i>		REGISTRAR'S SIGNATURE <i>John M. Beale</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Leonard J. Ruck, 5305 Harford Road #14			

83

12/2/83

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

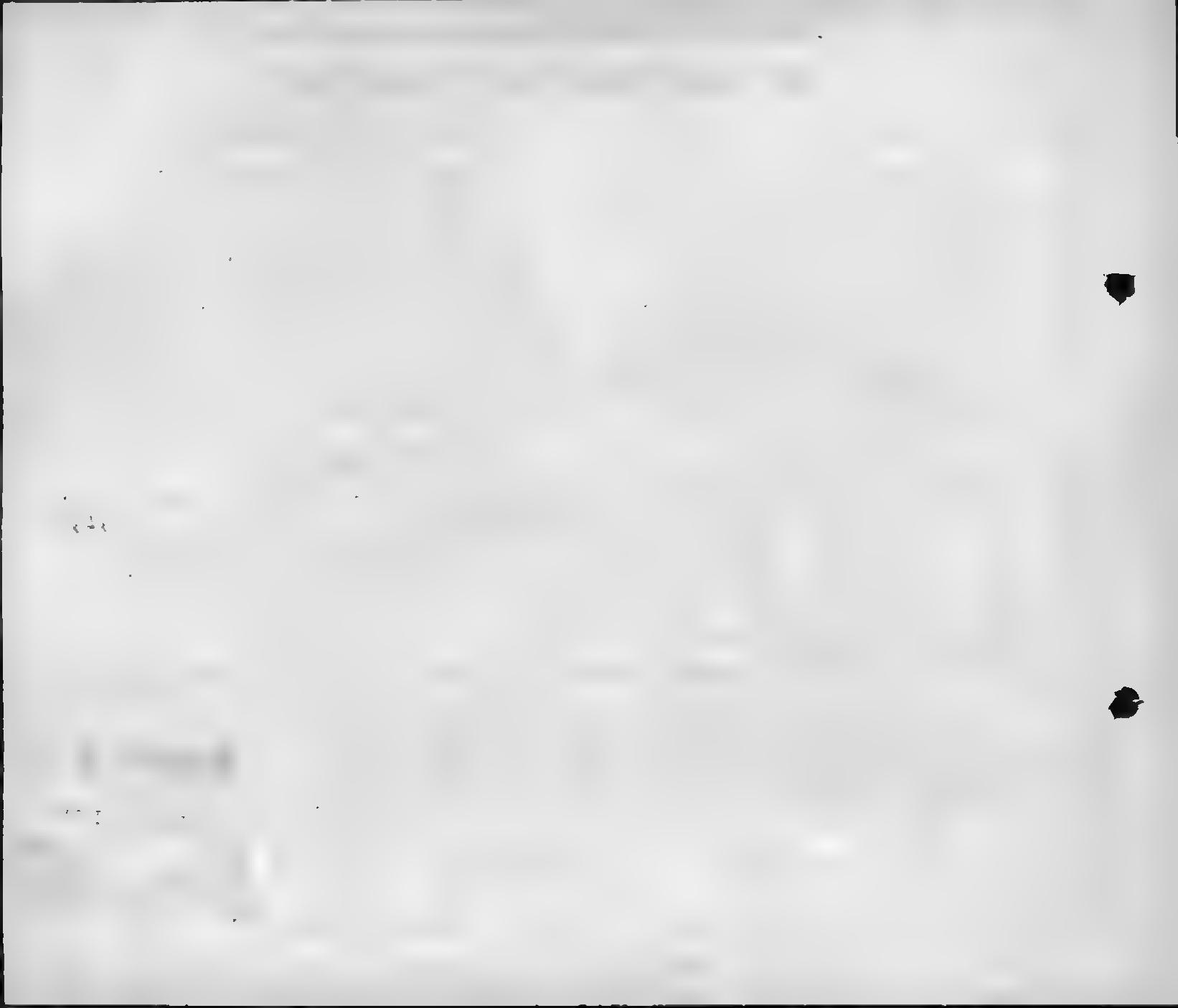
VS AISC 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18****1476 CERTIFICATE OF DEATH**

01442

Reg. Dist. No. 30

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town)		MARYLAND TOWN Catonsville		STATE CITY (If outside corporate limits, write RURAL and give nearest town)		COUNTY TOWN Catonsville	
LENGTH OF STAY (In this place)				STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4 Fayson Ave.				4 Fayson Ave.			
<b>3. NAME OF DECEASED</b> (First) Charles F. Hefner (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) Feb. 21 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH	9. AGE last birthday 68 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician and Contractor				11. BIRTHPLACE (State or foreign country) Md.			
13. FATHER'S NAME Henry Hefner				14. MOTHER'S MAIDEN NAME Lena Stern			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO		17. INFORMANT & ADDRESS 33. 3rd & 21st on Ave.			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b> IMMEDIATE CAUSE (A) <i>Coronary thrombosis</i> ANTECEDENT CAUSE(S) DUE TO (B) <i>Arterio-sclerotic cordis-vasa, disease</i> DISEASES OR CONDITIONS, IF ANY, (B) <i>Arterio-sclerotic cordis-vasa, disease</i> GIVING RISE TO THE ABOVE CAUSE DUE TO (C) STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) Balto.		(County)	(State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>Feb. 18, 1956</u> to <u>Feb. 21, 1956</u>, that I last saw the deceased alive on <u>Feb. 18, 1956</u>, and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>George H. Yeager</i> <b>ADDRESS</b> (Street, city, town, state) <i>Med. Arts Bldg. Balto. Md.</i> <b>DATE SIGNED</b> <i>Feb. 23, 1956</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF 1956-02-21		NAME OF CEMETERY OR CREMATORIAL Balto.		LOCATION (City, town, or county) Md.	
24. REC'D BY REGISTRAR DATE				REGISTRAR'S SIGNATURE <i>W. E. Harry</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Farley Funeral Home Catonsville, Md.</i>	



1477

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL) LENGTH OF STAY  
 OR (and give nearest town)  
 TOWN Towson (in this place)

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS 610 Marwood Road

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Baltimore  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN Towson  
 STREET ADDRESS (If rural give location)  
610 Marwood Road

3. NAME OF (First) (Middle) (Last)  
 DECEASED: ELIZABETH SWIRES HENRY

4. DATE (Month) (Day) (Year)  
 OF DEATH: February 17, 1956

5. SEX: Female 6. COLOR OR RACE: White 7. SINGLE, MARRIED, WIDOWED, DIVORCED.  
 (Specify): Married

8. DATE OF BIRTH: April 19, 1910

9. AGE last birthday 46 45 yrs.  
 IF UNDER 1 YEAR  
 Months 0 Days 0  
 IF UNDER 24 HRS.  
 Hours 0 Min. 0

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Pennsylvania 12. CITIZEN OF WHAT COUNTRY?  
 USA

## 13. FATHER'S NAME:

Joseph Swires

## 14. MOTHER'S MAIDEN NAME:

Bertha Ellen Craft

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS:

Maynard Henry, 610 Marwood Rd., Towson, Md.

18. MEDICAL CERTIFICATION  
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

IMMEDIATE CAUSE

CEREBRAL HEMORRHAGE

165

ANTECEDENT CAUSE (S)

(A) DUE TO HYPERTENSION

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(B) DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO

21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
While  Not while

M. at work  at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from FEB 17, 1956, to —, 19—, that I last saw the deceased  
alive on FEB 17, 1956, and that death occurred at 10:50 P.M. from the causes and on the date stated above.  
SIGNATURE Edward L. Zupuck ADDRESS M. D. 427 Stephen Rd DATE SIGNED 2/19/56

23. BURIAL, CREMATION, DATE THEREOF  
REMOVAL (SPECIFY)  
Burial

DATE REC'D BY LOCAL REGISTRAR  
REGISTRAR Feb. 20, 1956

NAME OF CEMETERY OR CREMATORIUM Phillipsburg Cemetery

LOCATION (City, town, or county) Phillipsburg, Penna.

(State)

24. FUNERAL DIRECTOR ADDRESS  
John Burns Son, Towson, Maryland

S. A. C. 1900

12

57

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01444

1478

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARGIN RESERVED FOR BUNDLING

1. PLACE OF DEATH: COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore		LENGTH OF STAY (In this place) Life	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Home, 8001 Duvall Ave.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
3. NAME OF DECEASED (First) (Type or Print) BERTHA		4. DATE OF DEATH (Month) Feb. (Day) 25, (Year) 1956	
5. SEX Female		6. COLOR OR RACE White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Wido		8. DATE OF BIRTH Oct 10-1880	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Switzerland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Spath.		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ACV	
17. INFORMANT AND ADDRESS Lives Rigoroso En 8001 Duvall Ave.		18. MEDICAL CERTIFICATION 1 year	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 170X Immediate cause (a)--- Carcinomatosis Antecedent cause(s) (b)--- Carcinoma of Breast Diseases or conditions, if any, (c)--- giving rise to the above cause stating the underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION 10-6-54		19b. MAJOR FINDINGS OF OPERATION Carcinoma of breast	
20. AUTOPSY Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, etc.) OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at m. Not While Work <input type="checkbox"/> At work <input type="checkbox"/> How did injury occur?	
22. I hereby certify that I attended the deceased from 9-17-52 to 2-25-56, 19....., that I last saw the deceased alive on 2-25-56, 19....., and that death occurred at 2:10 p.m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED Jan R. Mowen, M.D. 8019 Philadelphia Rd. Balt. 6, Md. 2-25-56			
23. BURIAL, CREMATION REMOVAL (Specify) 2-25-56		DATE THEREOF NAME OF CEMETERY OR CREMATORIAL Lion Luth. Cen	
DATE REG'D BY LOCAL REG.		LOCATION (City, town, or county) (State) Baltimore Md.	
REGISTRAR'S SIGNATURE Mar. 26 1956		24. FUNERAL DIRECTOR ADDRESS Reverend Lassalle Funeral Home 7401 Belair Rd.	

Oct 1887

OE A

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial (cremation, or removal).

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1386 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01445

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)	
BALTIMORE		a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
DUNDALK		DUNDALK	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
WILLIAM		1921 MAXWELL AVE	
3. NAME OF DECEASED (Type or print)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
WILLIAM		First MIDDLE LAST	
4. DATE OF DEATH		Month Day Year	
J. HERMAN		FEB 27 1956	
5. SEX		6. COLOR OR RACE	
M		W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input checked="" type="checkbox"/>		9. AGE (in years last birthday) 60 yrs.	
DIVORCED <input type="checkbox"/>		10. KIND OF BUSINESS OR INDUSTRY	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. BIRTHPLACE (State or foreign country)	
MILL WRIGHT		MARYLAND	
11. CITIZEN OF WHAT COUNTRY?			
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
AUGUST L. HERMAN		VANNAE OEHM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		17. INFORMANT	
420.1		HENRY L. HERMAN 25N STEEPLER ST	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO		Coronary Occlusion	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO	
(b)		Hypertension Cardi - Vascula	
DUE TO		Disease	
(c)		5-3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		3/1/56	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		March 1-56	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)	
DALE AVE.		BALTIMORE CEMETERY MD	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
J. B. DAVIS MD		2612	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE Mar. 1956		J. M. KELLY	

BUENA V. S.

MAR 5 1968

PFEILV

## 1479 CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH: COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>ANNE ARUNDEL</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>PASADENA, MD.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove Hosp.</u>		STREET ADDRESS <u>MAGOTHY BEACH</u> (If rural give location)	
3. NAME OF DECEASED. (Type or Print) <u>RAYMOND C GRADY</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>FEB 12 1956</u>	
5. SEX: <u>M</u> 6. COLOR OR RACE <u>W</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>WIDOWED</u>		8. DATE OF BIRTH: <u>July 1880</u> 9. AGE last birthday 75 yrs	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Fisherman</u> 10B. KIND OF BUSINESS OR INDUSTRY: <u>Self employed</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Benjamin Hicks</u>		14. MOTHER'S MAIDEN NAME: <u>Alice Grady</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mary Ann, Cecil Rd., Millersville, Md.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>Hypertensive cardiovascular disease</u>			
ANTECEDENT CAUSE (B) <u>Generalized arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory, street, office bldg., etc) <u>INJURY OCCUR?</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/10</u> <u>1956</u> , to <u>2/12</u> , <u>1956</u> , that I last saw the deceased alive on <u>2/12</u> , <u>1956</u> , and that death occurred at <u>145 P M</u> , from the causes and on the date stated above.		ADDRESS <u>Spring Grove Hosp.</u> DATE SIGNED <u>2/12/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 15, 1956</u> NAME OF CEMETERY OR CREMATORIUM <u>Cedar Hill Cem.</u> LOCATION (City, town, or county) <u>Brooklyn, N.Y.</u> (State) <u>N.Y.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb. 15, 1956</u>		24. FUNERAL DIRECTOR ADDRESS <u>Imperial Funeral Home &amp; Crematorium</u>	
REGISTRAR'S SIGNATURE <u>John E. Grady</u>			

W. INVYNG

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN & HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A1SC 155 104

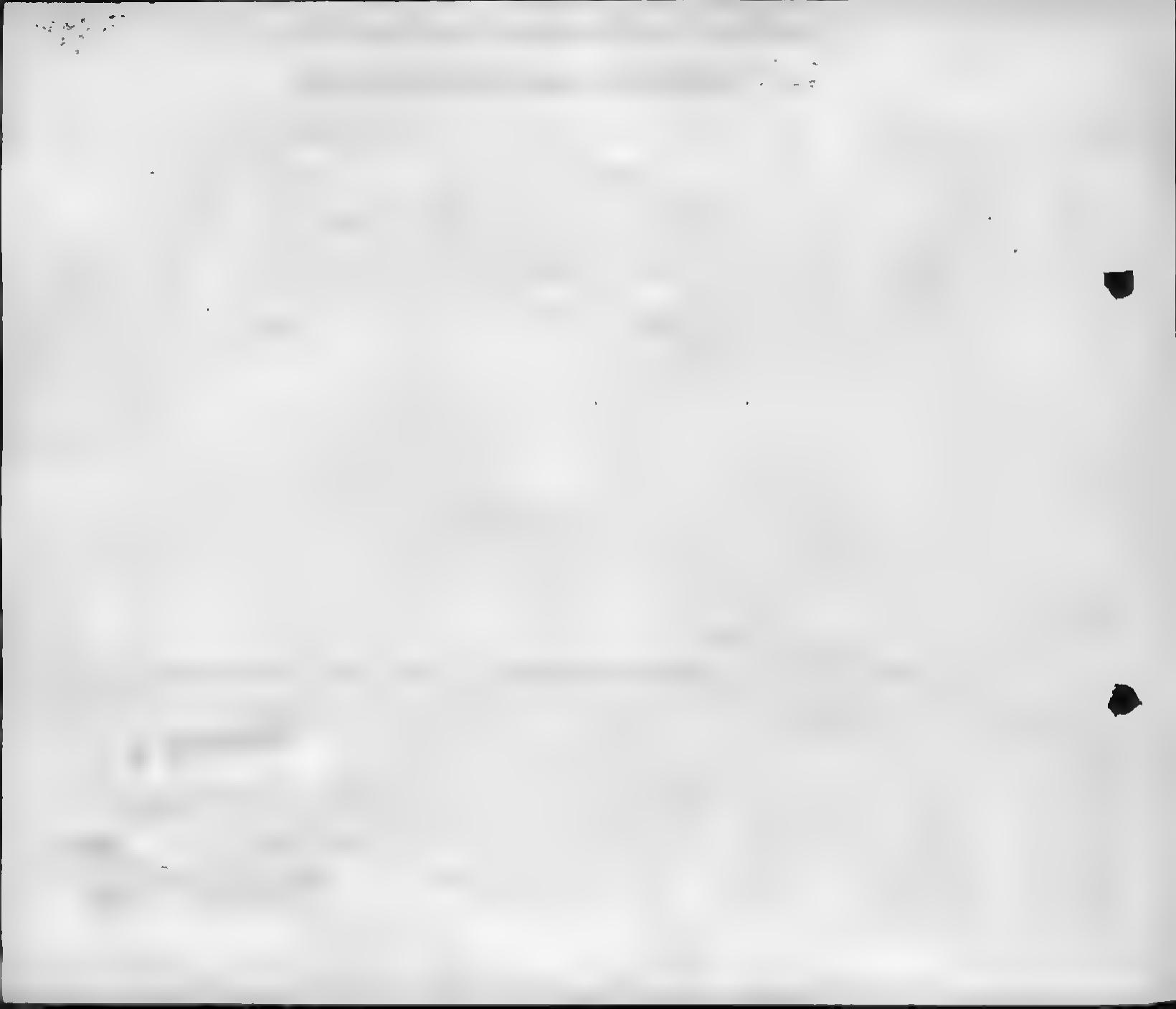
## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01447

## 1480 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	110.	MARYLAND	STATE 1. COUNTY 110.
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Catonsville		LENGTH OF STAY (In this place)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 Paradise Nursing Home		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville	
STREET ADDRESS 16 Sunmore Rd.		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
Robert J. Hilbrecht		19 50	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
		11. 1974	9. AGE last birthday 21 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Laborer		Steel Co.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Germany		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Joseph Hilbrecht		---	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT & ADDRESS	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE (A) Myocardial failure ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) giving rise to the above cause STATING UNDERLYING CAUSE LAST. DUE TO (C) Atherosclerosis CVD		5 days	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Benign prostatic hypertrophy		6 yrs 3 yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12-27, 1950, to 2-5, 1956, that I last saw the deceased alive on 2-4, 1956, and that death occurred at 6:30 A.M. from the causes and on the date stated above. SIGNATURE Stephen Lee Jaques M.D. 908 Frederick Rd Catonsville 2-7-56			
23. FUNERAL, CREMATION, REMOVAL (SPECIFY) Cremation		DATE THEREOF 2-3-56	ADDRESS (Street, city, town, state) LOCATION (City, town, or county) Baltimore Md.
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE T. E. Gandy	DATE SIGNED ADDRESS Folger General Home - Catonsville, Md.
DATE		25. FUNERAL DIRECTOR'S SIGNATURE	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01448

## 1481 CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

COUNTY

Balto

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN

HOSPITAL, OR  
INSTITUTION OR  
STREET ADDRESS3. NAME OF  
DECEASED  
(Type or Print)

4. SEX:

6

CO. OF OR

7

SINGLE

MARRIED

WIDOWED

DIVORCED

VACANT



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01449

## 1393 CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR and give nearest town  
 TOWN Baltimore (Rural) *Baltimore (Rural)*

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS 4412 Alan Drive

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Baltimore  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN Baltimore (Rural) *Baltimore (Rural)*

STREET ADDRESS  
 (If rural give location)  
 4412 Alan Drive

3. NAME OF (First) (Middle) (Last)  
 DECEASED: (Type or Print) William R. Hedges

4. DATE (Month) (Day) (Year)  
 OF DEATH: 2/27/ 1956

5. SEX: M 6. COLOR OR RACE: 7. SINGLE, MARRIED, WIDOWED, DIVORCED.  
 (Specify): Widowed

B. DATE OF BIRTH: 2/16/62

9. AGE last birthday IF UNDER 1 YEAR  
 Months Days Hours Min.  
 94 yrs. 1

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Customs Store  
 10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland  
 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

Richard Hedges

## 14. MOTHER'S MAIDEN NAME:

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES  
 (Yes, no, or unk.) (If Yes, give war or dates of service)  
 No

16. SOCIAL SECURITY NO.  
 --

## 17. INFORMANT &amp; ADDRESS:

James R. Hedges 4412 Alan Drive

18. MEDICAL CERTIFICATION  
 I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATHINTERVAL BETWEEN  
 ONSET AND DEATH

## IMMEDIATE CAUSE

(A)  
 DUE TO

*Arteriosclerotic Heart Disease*

## ANTECEDENT CAUSE (S)

(B)  
 DUE TO

*Cardiac Hypertrophy*

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE  
 STATING UNDERLYING CAUSE LAST.

(C)  
 DUE TO

*Cardiac Dilatation*II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
 YES  NO 

21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
 (If either, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (City or town) (County) (State)  
 INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
 OF INJURY M.

21E. INJURY OCCURRED  
 While  Not while   
 at work  at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 3, 1956 to Feb 27, 1956, that I last saw the deceased alive on Feb 27, 1956, and that death occurred at 9:05 P.M., from the causes and on the date stated above.  
 SIGNATURE *Vincent M. Messina* ADDRESS *M.D. 1403 S. Charles St* DATE SIGNED *2-28-56*

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORI

## LOCATION (City, town, or county)

(State)

Burial

3/2/56

Mt. Olivet Cem.

Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR *2-28-56*REGISTRAR'S SIGNATURE *John F. Denny*

## 24. FUNERAL DIRECTOR

John F. Denny, Inc. 715 Light St.

577

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01450

## 1482 CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL  
 OR and give nearest town)  
 TOWN Towson

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS 952 Dulaney Valley Rd.

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Baltimore  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN Towson

STREET ADDRESS (If rural give location)  
 952 Dulaney Valley Road #4

3. NAME OF  
 DECEASED  
 (Type or Print) Mr. William L. Hooper

4. DATE OF DEATH  
 (Month) (Day) (Year)  
 February 9th 1956

5. SEX male 6. COLOR OR RACE white 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married 8. DATE OF BIRTH Sept. 16, 1878 9. AGE last birthday 77

IF UNDER 1 YEAR  
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Auditor

10b. KIND OF BUSINESS OR INDUSTRY Arundel Corp

11. BIRTHPLACE (State or foreign country) Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?  
 USA

## 13. FATHER'S NAME

Luther E. Hooper

## 14. MOTHER'S MAIDEN NAME

Marie Wheeler

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
 (Yes, no, or unk.)

(If Yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS

Mrs. Anna E. Hooper, 952 Dulaney Valley Rd.

INTERVAL BETWEEN  
 ONSET AND DEATH

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## 18. MEDICAL CERTIFICATION

ischemic Thrombosis

IMMEDIATE CAUSE (A)

ANTECEDENT CAUSES (S) DUE TO

DISEASES OR CONDITIONS, IF ANY,  
 GIVING RISE TO THE ABOVE CAUSE  
 STATING UNDERLYING CAUSE LAST. (B)

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES  NO 

(County) (State)

21a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
 (If either, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, leinery,  
 OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

M.  White  Not whiteat work   at work

22. I hereby certify that I attended the deceased from Dec. 1954 to 1954, that I last saw the deceased alive on Dec. 1954, and that death occurred at 2 A.M. from the causes and on the date stated above.

## SIGNATURE

Dennis McGrath

ADDRESS (Street, city, town, state)

DATE SIGNED

8358 Loch Haven Blvd.

2/9/56

23. BURIAL, CREMATION,  
 REMOVAL (SPECIFY)

Burial

DATE THEREOF

2/11/1956

NAME OF CEMETERY OR CREMATORI

Parkwood Cemetery

LOCATION (City, town, or county)

Baltimore, Maryland

24. REC'D BY REGISTRAR

DATE

REGISTRAR'S SIGNATURE

Mabel Brays

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Leonard J. Ruck, 5305 Harford Road #11

1000

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01451

## 1483 CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND \_\_\_\_\_  
 CITY (If outside corporate limits, write RURAL  
 OR and give nearest town)  
 TOWN Towson 4 LENGTH OF STAY  
 (in this place)  
 HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS ~~1801 Darrick Drive~~  
~~7721 Glenridge P~~

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Baltimore  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN Towson 4 (Baynesville)  
 STREET  
 ADDRESS ~~(If rural give location)~~  
~~1801 Darrick Drive~~

## 3. NAME OF (First) (Middle) (Last)

DECEASED: MARY SAPP HRIB

## 4. DATE (Month) (Day) (Year)

OF DEATH: Feb. 6, 1956

## 5. SEX:

Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED  
 (Specify) Widow

## 8. DATE OF BIRTH:

Nov. 18, 1890

## 9. AGE last birthday IF UNDER 1 YEAR

65  
 yrs.

IF UNDER 24 HRS.  
 Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Austria

12. CITIZEN OF WHAT COUNTRY? USA

## 13. FATHER'S NAME:

Charles Sapp

IS WAB DECKED EVER IN U.S. ARMED FORCES?  
 (Yes, no, or unk.) (If Yes, give war or dates of service) No None

## 16. SOCIAL SECURITY NO.

None

## 14. MOTHER'S MAIDEN NAME:

Unknown

## 17. INFORMANT &amp; ADDRESS:

Mrs. Edw. Mehalick, Towson, Md.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
 ONSET AND DEATH

## IMMEDIATE CAUSE

(A)

Carcinoma of pancreas

6 weeks

## ANTECEDENT CAUSE (S)

DUE TO

DISEASES OR CONDITIONS, IF ANY,  
 GIVING RISE TO THE ABOVE CAUSE  
 STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES  NO

21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
 (If either, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (City or town) (County) (State)  
 INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
 OF INJURY

21E. INJURY OCCURRED  
 While  Not while   
 at work  at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/15, 1955, to 2/6, 1956; that I last saw the deceased

alive on 2/6, 1956 and that death occurred at 61 M. from the causes and on the date stated above.  
 SIGNATURE John Burne' Sapp

ADDRESS M. D. 55 1/2 Rock Run - Blk 2 1/2 DATE SIGNED 2/16/56

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county) (State)

Burial Feb. 9, 1956

REGISTRAR'S SIGNATURE

U. G. Bassett

## FUNERAL DIRECTOR

ADDRESS

DATE REC'D BY LOCAL REGISTRAR

2/9/56

John Burne' Sapp, Towson, Md.



## 1484 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH. Spring Grove State Hospital COUNTY Baltimore MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Catonsville 28 LENGTH OF STAY (in this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS			2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore 17 STREET ADDRESS (If rural give location) 133 W. Lanvale Street		
3. NAME OF DECEASED: (Type or Print) Olive Davison Hubner			4. DATE (Month) (Day) (Year) DEATH: 2 20 19 56		
5. SEX F 6. COLOR OR RACE W 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify). Widow			8. DATE OF BIRTH: 12/13/1867		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). None			9. AGE last birthday 88 IF UNDER 1 YEAR Months Days Hours Min.		
13. FATHER'S NAME George Davison			11. BIRTHPLACE (State or foreign country): Maryland		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No			12. CITIZEN OF WHAT COUNTRY? U.S.		
16. SOCIAL SECURITY NO Unknown			17. INFORMANT & ADDRESS: Mrs. George Thomas 200 Ridgewood Rd., Baltimore, Md.		
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 4771 IMMEDIATE CAUSE (A) Pneumonia ANTECEDENT CAUSE (B) DUE TO Chronic brain syndrome associated with DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) DUE TO senile brain disease Arteriosclerosis, generalized					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION			19C. INTERVAL BETWEEN ONSET AND DEATH 3 hours		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
22. I hereby certify that I attended the deceased from 7- alive on 2-20-1956, and that death occurred at 6:40PM, from the causes and on the date stated above. SIGNATURE Stella Wachler			21F. HOW DID INJURY OCCUR? ADDRESS Spring Grove State Hospital M. D. DATE SIGNED Catoonsville 28 Maryland 2-20-56 (State)		
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			DATE THEREOF 2/23/56 NAME OF CEMETERY OR CREMATORIUM Green Mount Crem. Balto., Md. DATE REC'D BY LOCAL REGISTRAR 2/23/56 REGISTRAR'S SIGNATURE W.M. J. Hubner & Sons - Balto., Md. FUNERAL DIRECTOR ADDRESS		



01453

STATE DEPARTMENT OF HEALTH

MARYLAND

## 1485 CERTIFICATE OF DEATH

Reg. Dist. No. *JK*

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
Baltimore MARYLAND		Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN Fort Howard		TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS 811 Somerset Street (If rural, give location)	
3. NAME OF DECEASED (Type or Print) ROBERT		4. DATE OF DEATH February 28 1956	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 6/15/96
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Albert Hudson		11. BIRTHPLACE (State or foreign country) Reading, Pennsylvania	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) Yes		16. SOCIAL SECURITY NO. WW 228-18-7987	
17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
Immediate cause (a) CARCINOMA OF PROSTATE WITH GENERALIZED BONY METASTASIS			
Antecedent cause(s)  Diseases or conditions, if any, (b)... giving rise to the above cause stating the underlying cause last  (c)...			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? ADDRESS
22. I hereby certify that <input checked="" type="checkbox"/> attended the deceased from Sept. 24, 1955, to Feb. 28, 1956, <input type="checkbox"/> in the <input type="checkbox"/> located XXXXXX and that death occurred at 10:43A. m., from the causes and on the date stated above. SIGNATURE <i>D. D. Mark, M.D.</i> (Degree or title) ADDRESS DATE SIGNED VAH, FORT HOWARD, MARYLAND 2-29-56			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE 3/2/56	NAME OF CEMETERY OR CREMATORIAL Baltimore National Cemetery, Baltimore, Maryland
DATE REC'D BY LOCAL REC'D 3/1/56		REGISTRAR'S SIGNATURE A. W. Hadrich dmr.	LOCATION (City, town, or county) (State) Charles R. Law Mortuary, 802-04 Madison Av. Baltimore, Maryland
24. FUNERAL DIRECTOR		ADDRESS	



## 1486 CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH.

COUNTY Baltimore  
 CITY (If outside corporate limits, write RURAL  
 OR and give nearest town)  
 TOWN Fort Howard

MARYLAND  
 LENGTH OF STAY  
 (in this place)  
 15 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED.

STATE Maryland COUNTY  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN Baltimore

STREET ADDRESS  
 (If rural give location)

2 Chesapeake Avenue

50 HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Veterans Administration Hospital

3. NAME OF  
DECEASED  
(Type or Print)

(First) JAY (Middle) (NMI)

(Last) HUGUNIN

4. DATE (Month) (Day) (Year)  
 OF DEATH February 24 1956

## 5. SEX

6. COLOR OR  
RACE7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify): Married

## 8. DATE OF BIRTH

10/3/89

## 9. AGE last birthday

66

IF UNDER 24 HRS.  
 Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired): Foreman10B. KIND OF BUSINESS  
OR INDUSTRY  
Concrete Company11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT  
COUNTRY?

Clintonville, Wis.

U.S.A.

## 13. FATHER'S NAME:

Casimir Hugunin

## 14. MOTHER'S MAIDEN NAME:

Jennie Moss

15. WAR DECEASED EVER IN U.S. ARMED FORCES  
(Yes, no, or unknown) (If Yes, give war or date  
of service) Yes W.H.I

## 16. SOCIAL SECURITY NO.

218 05 7621

## 17. INFORMANT &amp; ADDRESS:

Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.

INTERVAL BETWEEN  
ONSET AND DEATH

SUDDEN

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## IMMEDIATE CAUSE

(A) MYOCARDIAL INFARCTION?

## DUE TO

## ANTECEDENT CAUSE (S)

## (B)

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

## DUE TO

## (C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING CEREBRAL THROMBOSIS RIGHT MIDDLE CEREBRAL  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH ARTERY WITH LEFT HEMIPLEGIA: PERNICIOUS ANEMIA

## 19A. DATE OF OPERATION

## 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES  NO 21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
While  Not while   
at work  at work 

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 9, 1956 to Feb. 24, 1956

and that death occurred at 2:30 P.M. from the causes and on the date stated above.  
ADDRESS DATE SIGNED  
SIGNATURE

JOHN A. SURMONTE, M.D.

VAH, Fort Howard, Md.

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county)

(State)

Burial

2-28-56

Baltimore National

Baltimore, Maryland

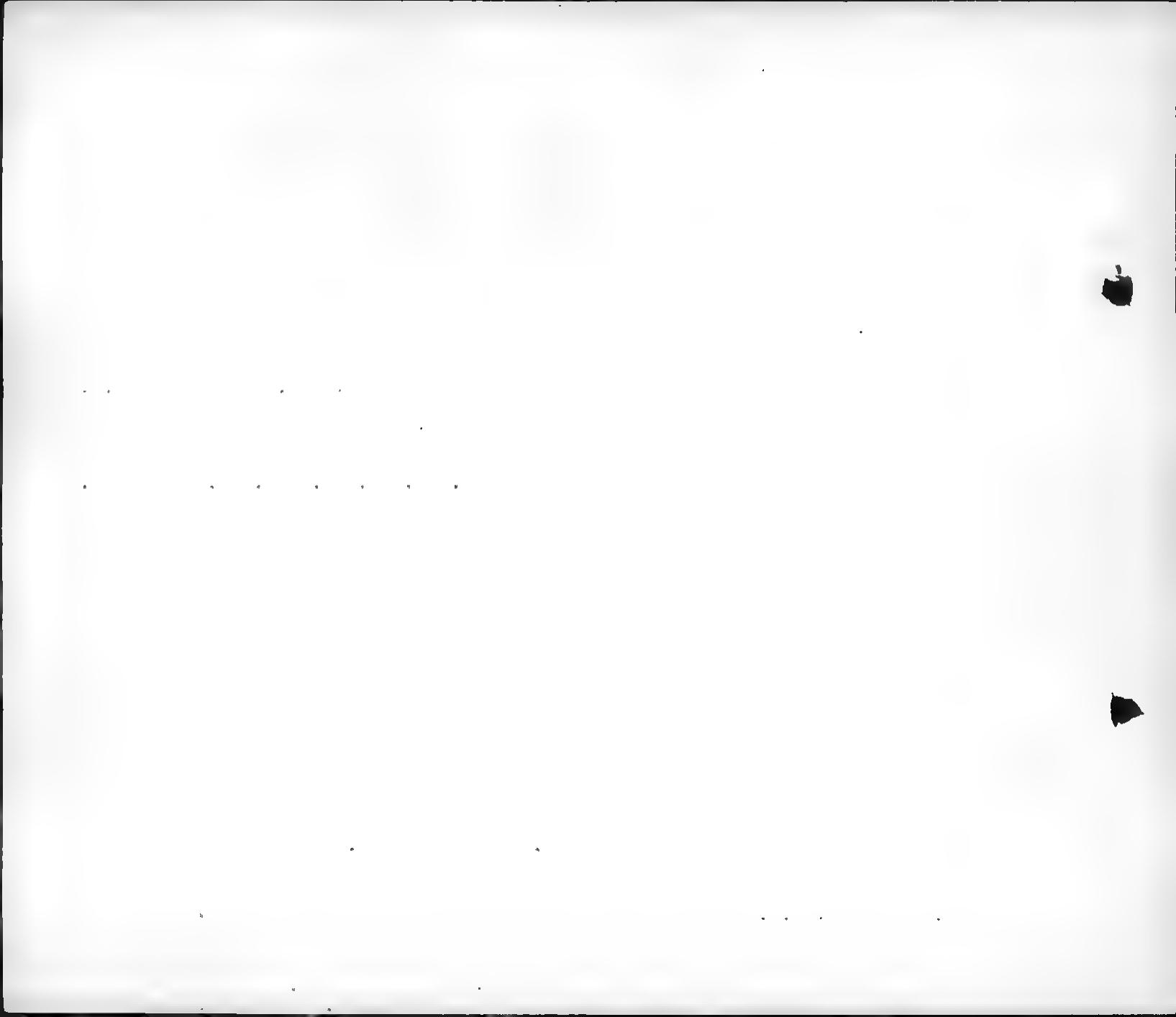
DATE REC'D BY LOCAL  
REGISTRAR 3/27/56

REGISTRAR'S SIGNATURE

Q. 24. FUNERAL DIRECTOR  
Wm. Cook-Blight Inc.

ADDRESS

6009 Harford Rd. Baltimore, Maryland



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film 193 2-29-56 et

01455

## 1487 CERTIFICATE OF DEATH

Reg. Dist. No. 50

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
 OR and give nearest town) (in this place)  
 TOWN Catonsville 36 hours  
 HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS Spring Grove St. Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY Prince George  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN Washington 27, DC  
 STREET  
 ADDRESS 503 - 65 Ave NE (If rural give location)

3. NAME OF  
 DECEASED:  
 (Type or Print)(First) Benjamin (Middle) Newton (Last) Hutchinson4. DATE (Month) (Day) (Year)  
 OF  
 DEATH: 2 / 19 19565. SEX: Male6. COLOR OR  
 RACE: W 7. SINGLE, MARRIED,  
 WIDOWED, DIVORCED  
 (Specify): Married8. DATE OF BIRTH: Oct. 23, 18879. AGE last birthday 6810. UNDER 1 YEAR  
 Months 0 Days 0 Hours 0 Min. 010A. USUAL OCCUPATION (Give kind of  
 work done during most of working life,  
 even if retired): Cabinet-maker10B. KIND OF BUSINESS  
 OR INDUSTRY:11. BIRTHPLACE (State or foreign country): Missouri12. CITIZEN OF WHAT  
 COUNTRY? U.S.

## 13. FATHER'S NAME:

Lemul Hutchinson

## 14. MOTHER'S MAIDEN NAME:

unk.15. WAR DECEASED EVER IN U.S. ARMED FORCES  
 (Yes, no, or unk.) (If Yes, give war or dates  
 of service) yes 1907-1910

16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS:

unk.This Hosp. recordsINTERVAL BETWEEN  
 ONSET AND DEATH

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

400.0

IMMEDIATE CAUSE

(A)  
 DUE TOUraemia unqualifiedunk.

ANTECEDENT CAUSE (S)

(B)  
 DUE TODISEASES OR CONDITIONS, IF ANY,  
 GIVING RISE TO THE ABOVE CAUSE  
 STATING UNDERLYING CAUSE LAST.

(C)

General Arteriosclerosisunk.unk.II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO 21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,  
 OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
 INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
 OF INJURY21E. INJURY OCCURRED  
 While  Not while   
 at work  at work 

21F. HOW DID INJURY OCCUR?

M.

22. I hereby certify that I attended the deceased from 2/18, 1956, to 2/19, 1956, that I last saw the deceasedalive on 2/19, 1956, and that death occurred at 9:15 P.M. from the causes and on the date stated above.  
 SIGNATURE

ADDRESS DATE SIGNED

Bruno Radanska M. D. Spring Grove St. Hosp. 2/19/5623. BURIAL, CREMATION,  
 REMOVAL (SPECIFY)DATE THEREOF 2-20-1956NAME OF CEMETERY OR CREMATORIAL Spring GroveLOCATION (City, town, or county) Arlington Nat'l. (State) VADATE REC'D BY LOCAL  
 REGISTRAR 2/15/56REGISTRAR'S SIGNATURE W. E. Burns24. FUNERAL DIRECTOR W. E. BurnsADDRESS 1101 N. Highland Ave.

EE3

## 1488 CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH

COUNTY *Baltimore*  
 CITY (If outside corporate limits, write RURAL  
 OR  
 and give nearest town)  
 TOWN *Eastonaville*

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS  
*Baton Ridge Nursing*

## MARYLAND

LENGTH OF STAY  
(In this place)

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE *Md*  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN *Baltimore*

STREET  
 ADDRESS *5412 Pembroke Ave*

COUNTY *Baltimore*3. NAME OF  
 DECEASED  
 (Type or Print)5. SEX *F*6. COLOR OR  
 RACE *W.*7. SINGLE, MARRIED,  
 WIDOWED, DIVORCED,  
 (Specify) *W.*8. DATE OF BIRTH *Nov. 22, 1878*9. AGE last birthday *77*10. IF UNDER 1 YEAR  
 YRS. *Months*11. IF UNDER 24 HRS  
 Days12. IF UNDER 24 HRS  
 Hours13. CITIZEN OF WHAT  
 COUNTRY? *U.S.A.*10a. USUAL OCCUPATION (Give kind of work  
 done during most of working life, even if  
 retired) *Housewife*10b. KIND OF BUSINESS  
 OR INDUSTRY *—*11. BIRTHPLACE (State or foreign country) *Maryland*13. FATHER'S NAME *Unknown*14. MOTHER'S MARRIED NAME *Unknown*15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
 (Yes, no, or unk.) *—*(If Yes, give war or dates of service) *—*16. SOCIAL SECURITY NO. *—*17. INFORMANT & ADDRESS *Frederick H. Jenkins, Phoenix, NC*INTERVAL BETWEEN  
 ONSET AND DEATH

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE *(A)* *Chronic failure in heart & lungs*ANTECEDENT CAUSE(S) DUE TO *pregnancy*DISEASES OR CONDITIONS, IF ANY, *(B)*  
 GIVING RISE TO THE ABOVE CAUSE  
 STATING UNDERLYING CAUSE LAST. *(C)* *—*

2 days

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.*Cerebral vascular thrombosis*

4 days

19a. DATE OF OPERATION *—*19b. MAJOR FINDINGS OF OPERATION *—*

20. AUTOPSY?

YES  NO 21a. ACCIDENT WAS UNDERLYING   
 OR CONTRIBUTING  CAUSE OF DEATH  
 (If either, NOTIFY MEDICAL EXAMINER) *—*21b. PLACE (Home, farm, factory,  
 OF INJURY street, office bldg., etc.) *—*21c. WHERE DID INJURY OCCUR? (City or town) *—*(County) *—*(State) *—*21d. TIME OF INJURY (Month) *—* (Day) *—* (Year) *—* (Hour) *—*21e. INJURY OCCURRED  
 White  Not white   
 M. at work  at work 21f. HOW DID INJURY OCCUR? *—*22. I hereby certify that I attended the deceased from *1951*alive on *Feb. 9, 1952*end that death occurred at *10 A.M.* from the causes and on the date stated above.SIGNATURE *Frederick H. Jenkins*ADDRESS (Street, city, town, state) *4605 Edmondson Ave*DATE SIGNED *2/15/52*23. BURIAL, CREMATION,  
 REMOVAL (SPECIFY) *Burial*DATE THEREOF *2/14/52*NAME OF CEMETERY OR CREMATORIAL *Forest Haven Presbyterian Balt.*LOCATION (CITY, TOWN, OR COUNTY) *Baltimore*(State) *MD.*24. REC'D BY REGISTRAR *—*REGISTRAR'S SIGNATURE *F. E. Farago*25. FUNERAL DIRECTOR'S SIGNATURE *Forest Haven*ADDRESS *3025 E. 36th St., Baltimore*DATE *—*

15, 1952

444

## 1489 CERTIFICATE OF DEATH

Reg. Dist. No. 30

Items 3, 13, 14, 16: Fill in ~~1489~~ 1489

## 1. PLACE OF DEATH: Spring Grove State Hospital

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)LENGTH OF STAY  
(in this place)

TOWN Catonsville 28

2 mos.

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS Spring Grove State Hospital3. NAME OF  
DECEASED:  
(Type or Print)6 COLOR OR  
RACE: M7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify): single8. DATE OF BIRTH:  
2 - 10 - 8210A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired): ex-farmer10B. KIND OF BUSINESS  
OR INDUSTRY: 9122A

10C. SOCIAL SECURITY NO.: Unknown

10D. WAR DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unk.) (If Yes, give war or dates  
of service): unk.10E. INFORMANT & ADDRESS:  
Miss Dona Johnson, Route #1  
Havre de Grace, Md.10F. MOTHER'S MAIDEN NAME:  
Rosie/ Rosa Boyer

10G. DATE OF OPERATION: 19A. DATE OF OPERATION:

10H. MAJOR FINDINGS OF OPERATION:

10I. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER):10J. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.):10K. WHERE DID (City or town)  
INJURY OCCUR? (County) (State):10L. TIME (Month) (Day) (Year) (Hour)  
OF INJURY: M.21E. INJURY OCCURRED  
While  Not while   
at work  at work 

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-21-1955, to 2-20-1956, that I last saw the deceased

alive on 2-20-1956, and that death occurred at 9:50P M, from the causes and on the date stated above.

SIGNATURE: Sheila Wadeler

ADDRESS: Spring Grove State Hospital

DATE SIGNED: 2-21-56

23. BURIAL, CREMATION, DATE THEREOF  
REMOVAL (SPECIFY): Burial Feb. 23, 1956 Rock Run Cem. Harford Co. Md.

NAME OF CEMETERY OR CREMATORIUM: LOCATION (City, town, or county):

DATE REC'D BY LOCAL REGISTRAR: 2/21/56

REGISTRAR'S SIGNATURE: Harry H. S. Bailey, Warfingford Md.

24. FUNERAL DIRECTOR: ADDRESS:

1966  
FEB 23 1966

1502

01458

## MARYLAND STATE DEPARTMENT OF HEALTH

1490 CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

Item 9. film G193 3-6-56 et

1. PLACE OF DEATH  
CITY  
OR  
give nearest town  
TOWN

BALTIMORE

MARYLAND

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

CHATHAM LEE

LENGTH OF STAY  
(In this place)

50

2. USUAL RESIDENCE (HOME) OF DECEASED  
STATE

COUNTY

Maryland

Balto.

CITY (If outside corporate limits, write RURAL and  
give nearest town)  
OR  
TOWN

CHATHAM LEE

STREET  
ADDRESS

(If rural, give location)

VALLEY ROAD

3. NAME OF  
DECEASED  
(Type or Print)

(First)

(Middle)

(Last)

4. DATE  
OF  
DEATH

(Month)

(Day)

(Year)

5. SEX

6. COLOR OR RACE

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)10b. KIND OF BUSINESS OR  
INDUSTRY

10c. FATHER'S NAME

10d. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of  
service)

10e. SOCIAL SECURITY NO.

10f. INFORMANT AND ADDRESS

10g. MEDICAL CERTIFICATION

11. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) accidental drowning

INTERVAL BETWEEN  
ONSET AND DEATH

4 days.

Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last

(b) epilepsy

10 yrs.

(c)

12. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

(d) none

13. DATE OF OPERATION

14. MAJOR FINDINGS OF OPERATION

(e) none

20. AUTOPSY?

Yea  No 15. IF ALL CAUSE WAS  
PRIMARY OR CONTRIBUTING  
CAUSE OF DEATHPLACE (Home, farm, factory, street,  
of office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Day) (Year) (Hour)  
OF INJURYINJURY OCCURRED  
While at work  
Not while at work

HOW DID INJURY OCCUR?

Baltimore, Garrison

Balto.

Md.

16. DATE OF AUTOPSY

17. DATE OF EXAMINATION

18. DATE OF EXAMINATION

19. DATE OF EXAMINATION

20. DATE OF EXAMINATION

21. DATE OF EXAMINATION

22. DATE OF EXAMINATION

23. DATE OF EXAMINATION

24. DATE OF EXAMINATION

25. DATE OF EXAMINATION

26. DATE OF EXAMINATION

27. DATE OF EXAMINATION

28. DATE OF EXAMINATION

29. DATE OF EXAMINATION

30. DATE OF EXAMINATION

31. DATE OF EXAMINATION

32. DATE OF EXAMINATION

33. DATE OF EXAMINATION

34. DATE OF EXAMINATION

35. DATE OF EXAMINATION

36. DATE OF EXAMINATION

37. DATE OF EXAMINATION

38. DATE OF EXAMINATION

39. DATE OF EXAMINATION

40. DATE OF EXAMINATION

41. DATE OF EXAMINATION

42. DATE OF EXAMINATION

43. DATE OF EXAMINATION

44. DATE OF EXAMINATION

45. DATE OF EXAMINATION

46. DATE OF EXAMINATION

47. DATE OF EXAMINATION

48. DATE OF EXAMINATION

49. DATE OF EXAMINATION

50. DATE OF EXAMINATION

51. DATE OF EXAMINATION

52. DATE OF EXAMINATION

53. DATE OF EXAMINATION

54. DATE OF EXAMINATION

55. DATE OF EXAMINATION

56. DATE OF EXAMINATION

57. DATE OF EXAMINATION

58. DATE OF EXAMINATION

59. DATE OF EXAMINATION

60. DATE OF EXAMINATION

61. DATE OF EXAMINATION

62. DATE OF EXAMINATION

63. DATE OF EXAMINATION

64. DATE OF EXAMINATION

65. DATE OF EXAMINATION

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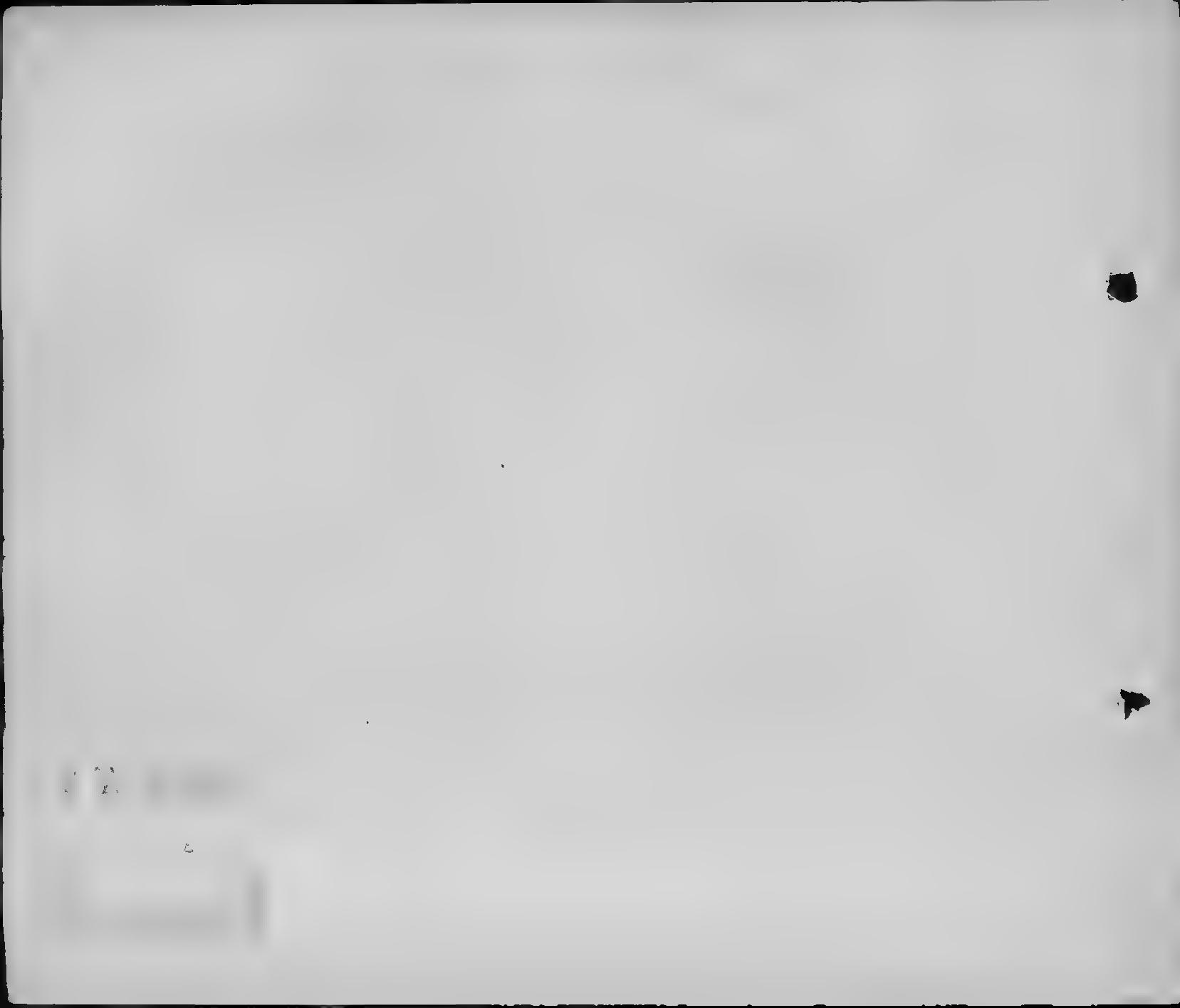
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**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL** The law requires that the death certificate be executed within 24 hours after death. After this bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A1SC 4-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

01459

**1491 CERTIFICATE OF DEATH**

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY		MARYLAND		STATE		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN Catonsville				Catonsville		38 Dunverian Rd.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		38 Dunverian Rd.		STREET ADDRESS		(If rural give location)	
				38 Dunverian Rd.			
<b>3. NAME OF DECEASED</b> (First) <b>Allie</b> (Middle) <b>Owens</b> (Last) <b>Kane</b> (Type or Print)				<b>4. DATE (Month) (Day) (Year)</b> <b>OF DEATH</b> Feb. 1, 1959			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widow</b>	8. DATE OF BIRTH	9. AGE (at birthday yrs.)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min.
F			Jan. 5, 1981	75			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress ret</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing Mfg.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>			
13. FATHER'S NAME -- Owens				14. MOTHER'S MAIDEN NAME Not Known			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Aubrey O Kane</b> 38 Dunverian Rd.			
<b>18. MEDICAL CERTIFICATION</b>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Myocardial Decompenstation</b>							
ANTECEDENT CAUSE(S) DUE TO (B) <b>Ch. Hypertension Cardio-Vasc - Renal Disease</b>							
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE DUE TO (C) STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>2-13-56</b> to <b>2-10-56</b> , that I last saw the deceased alive on <b>2-9-56</b> , and that death occurred at <b>7:30A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Maurice J. Gilligan</b> ADDRESS (Street, city, town, state) <b>M. 6209 Frederick Rd. Baltimore Md.</b> DATE SIGNED <b>2/11/56</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>2-13-56</b>		NAME OF CEMETERY OR CREMATORIAL <b>Loudon Park Cem.</b>		LOCATION (City, town, or county) <b>Baltimore Md.</b> (State)	
24. REC'D BY REGISTRAR DATE		REGISTRAR'S SIGNATURE <b>W. G. H. Jr.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Fussey &amp; Son at Home, Baltimore Md.</b>		ADDRESS	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1492 CERTIFICATE OF DEATH

Reg. Dist. No.

014604

## 1. PLACE OF DEATH.

COUNTY BALTIMORE

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN FORT HOWARD

MARYLAND

LENGTH OF STAY  
(in this place)

15 hrs; 15 min.

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

VAH, FORT HOWARD, MARYLAND

3. NAME OF  
DECEASED  
(Type or Print)

OSCAR

S.

KEIM

4. SEX

MALE

WHITE

5. COLOR OR  
RACESINGLE, MARRIED,  
WIDOWED, DIVORCED  
(Specify): MARRIED

6. DATE OF BIRTH

May 14, 1874

7. AGE last birthday

IF UNDER 1 YEAR  
Months Days Hours Min.

81

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life  
even if retired)

Storekeeper's

10B. KIND OF BUSINESS  
OR INDUSTRY

Truck Company

13. FATHER'S NAME

Clerk

Franklin Keim

15. WAS DECEASED EVER IN U.S. ARMED FORCES  
(Yes, no, or unknown) (If Yes, give war or dates  
of service)

Yes

SAW

16. SOCIAL SECURITY NO.

207-01-7523

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## IMMEDIATE CAUSE

## 18. MEDICAL CERTIFICATION

(A) ARTERIOSCLEROTIC HEART DISEASE

## ANTECEDENT CAUSE (S):

DUE TO

GENERALIZED ARTERIOSCLEROSIS

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

9 MONTHS

UNKNOWN

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.CEREBRAL THROMBOSIS, RIGHT MIDDLE  
CEREBRAL ARTERY

5 YEARS

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO 21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory  
OR INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(County) (State)

21D. TIME (Month) (Day) (Year)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

M.

While  Not while   
at work  at work 

11:00 AM

2:15 AM

22. I hereby certify that I attended the deceased from Feb. 21, 1956, to Feb. 22, 1956, ~~and that death occurred at 2:15 AM, from the causes and on the date stated above.~~

ADDRESS

DATE SIGNED

SIGNATURE

W. C. Dudley, M.D.

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORI

LOCATION (U. S. TOWN, OR COUNTY)

(State)

Burial

FEB. 24/56

Baltimore National Cemetery Baltimore, Maryland

DATE REC'D. BY LOCAL  
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

Vitzke Funeral Directors

ADDRESS

1101 Edmondson Ave., Baltimore, Md.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01461

1493 Item 12, Film GL 92 2-20-56

30

## CERTIFICATE OF DEATH

Reg. Dist. No.

Th

THIS IS A PERMANENT RECORD.  
PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly.

THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

1. NAME OF DECEASED  
(Type or Print)

Clara King

2. DATE  
OF  
DEATH

Feb 11, 1956

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Baltimore County*  
B. FULL NAME OF HOSPITAL OR INSTITUTION *The House in the Pines Md*  
The House in the Pines Md  
16 Fusting Ave, Catonsville

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE *Maryland*B. COUNTY *before admission*

c. LENGTH OF STAY IN BALTIMORE

Yrs.  
Mo.  
Days5. SEX *Female* 6. COLOR OR RACE *White* 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) *Widow*10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Housework*

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Raphael Wolf

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) *No* (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH *Aug 1, 1867* 9. AGE (In years last birthday) *88* 10. Under 1 Year *6* 11. Under 24 Hours *10*11. BIRTHPLACE (State or foreign country) *Germany*12. CIT. ZEN OF WHAT COUNTRY? *U.S.A.*

14. MOTHER'S MAIDEN NAME

Rosina Sonneberg

17. INFORMANT *Louis Rosenstein, 2601 Madison Ave* ADDRESS

INTERVAL BETWEEN ONSET AND DEATH

1 day

18.

## DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

## CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

*Acute Coronary thrombosis**arteriosclerosis - Senile -**Chronic coronary disease*

ML CERTIFICATION

D

## OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

YES  NO 

m.

WHILE AT WORK

NOT WHILE AT WORK

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

Dec 2, 1956

to 1956

1956, that (I) (we) last saw the deceased alive on Feb 9, 1956,

and that death occurred at 12:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Dr. Bernard Cohen

23B. ADDRESS

The Marylander Apt

23C. DATE SIGNED

2-11-56

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 

24A. BURIAL, CREMATION OR REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORIUM

24D. LOCATION (City, town, or county) (State)

Burial

2-13-56

Oheb Shalom Cemetery

Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

David R. Martin ADDRESS

FEB 12 1956 Huntington George

David R. Martin 1902 Eutaw Place

BUREAU V. S.

FEB 16 1956

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01462

## 1494 CERTIFICATE OF DEATH

Reg. Dist. No. 30

<b>1. PLACE OF DEATH</b>			<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>		
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Baltimore Catonsville	MARYLAND LENGTH OF STAY (In this place) 10 Days	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY Baltimore Catonsville	STREET ADDRESS (If rural give location) 331 Oella Avenue
HOSPITAL OR INSTITUTION OR STREET ADDRESS 331 Oella Avenue			331 Oella Avenue		
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) GEORGIA KNABE			<b>4. DATE OF DEATH</b> February 8 1956.		
5. SEX Female	6. COLOR OR FACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH February 9, 1880.	9. AGE last birthday 75 yrs.	10. UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Judson Boswell			14. MOTHER'S MAIDEN NAME Martha Ann Severen		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Ernest Knabe Route 3, Box 40 Ellicott City, Md.		
<b>18. MEDICAL CERTIFICATION</b> <i>Bronchopneumonia</i> 191X IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO — DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE DUE TO — STATING UNDERLYING CAUSE LAST, DUE TO — (C)					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. DATE OF OPERATION None		21b. MAJOR FINDINGS OF OPERATION None		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2/6, 1956, to 2/8, 1956, that I last saw the deceased alive on 2/7, 1956, and that death occurred at 3 A.M. from the causes and on the date stated above. SIGNATURE <i>George E. Beery, M.D.</i> ADDRESS (Street, city, town, state) <i>Church St. Ellicott City, Md.</i> DATE SIGNED <i>2/19/56</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Feb. 11, 1956.	NAME OF CEMETERY OR CREMATORIAL Good Shepherd Cemetery	LOCATION (City, town, or county) Ellicott City, Maryland.		
24. REC'D BY REGISTRAR DATE 2/9/56	REGISTRAR'S SIGNATURE <i>T.E. Harry</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Caston Sons, Catonsville 28, Md.</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01463

1394

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Relay</b>		b. COUNTY <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>30 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Relay</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Viaduct Ave.</b>		d. STREET ADDRESS <b>Viaduct Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Emory E. Knodt, Sr.</b>	First	Middle	Last
4. DATE OF DEATH <b>February 25</b>	Month	Day	Year <b>19 56</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 24, 1880</b>
9. AGE (In years last birthday) <b>75</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. R.R.</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Knodt</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>181X</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Charles B. Knodt 1007 Francis Ave.</b>		Address <b>Relay 27</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Bladder 6 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>181X</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		<b>General carcinomatosis 6 yrs</b>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 25, 1956</b> to <b>Feb. 25, 1956</b> that I last saw the deceased alive on <b>Feb. 25, 1956</b> , and that death occurred at <b>7:00</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>609 Main St. Eldridge 27 MD</b>	
ACTUAL SIGNATURE <b>B. B. Bannister, M.D.</b>		DATE SIGNED <b>Feb. 25, 1956</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 28, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Amrose Inc. 1328 Sulphur Spring Rd.</b>		24a. REC'D BY REGISTRAR DATE <b>Dr. G. F. M. Kiff</b>	
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with  
police 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FEB

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01464

1495

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Sparrows Point		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sparrows Point	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7409 North Point Road		STREET ADDRESS (If rural, give location) 7409 North Point Road	
3. NAME OF DECEASED (Type or Print)	(First) JOHN	(Middle) OSCAR	(Last) KOLSTROM
4. DATE (Month) OF DEATH	Feb. 12	(Day) 19 56	(Year)
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married	8. DATE OF BIRTH Dec. 25, 1890
9. AGE last birthday 65 yrs.	10. KIND OF BUSINESS OR INDUSTRY Steel Co.	11. BIRTHPLACE (State or foreign country) Finland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Kolstrom		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.	16. SOCIAL SECURITY NO. 213-07-2883	17. INFORMANT Mrs. Hilma Kolstrom 7409 North Point Road	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
4 Immediate cause Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		Coronary Thrombosis Atherosclerotic Ht. Disease	
		2 hrs 3 yrs	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?	
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) OF INJURY	(Day) m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct., 1955, to Feb. 12, 1956, that I last saw the deceased alive on Feb. 12, 1956, and that death occurred at 2:00 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Feb. 15, 1956	NAME OF CEMETERY OR CREMATORIAL Oak Lawn Cemetery	LOCATION (City, town, or county) Colgate, Md.
DATE REC'D BY LOCAL REC'D	REG.	REGISTRAR'S SIGNATURE James T. Moore	FUNERAL DIRECTOR Ullrich Funeral Home 2112 Dundalk Ave.

BUREAU V. S.

FEB 15 1956

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-5 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 1496 CERTIFICATE OF DEATH

01465

Reg. Dist. No. 30

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY	CLIC.		MARYLAND	STATE	COUNTY
CITY (If outside corporate limits, write RURAL or OR and give nearest town)			LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	110.
TOWN	Catonsville			TOWN	Catonsville
HOSPITAL OR INSTITUTION OR STREET ADDRESS	House in the Pines		STREET ADDRESS	(If rural give location)	
			210 Shady Nook Court		
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
(First) John S.			(Month) (Day) (Year)		
(Middle) Inhol			July 17 '56		
(Last) Kopelke					
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR Months Deys
		Single	July 1, 1912	57 yrs.	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener			10b. KIND OF BUSINESS OR INDUSTRY		
			Private Homes		
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Wisc.					
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Fred Kopelke			Minnie Hardt		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		
(If Yes, give war or date of service)			-----		
17. INFORMANT & ADDRESS					
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE			Myocardial Dicompensation		
ANTECEDENT CAUSE(S) DUE TO			12:20		
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE STATING UNDERLYING CAUSE LAST. DUE TO			Chronic Hypertension, Cere. Vas. - Renal Disease		
(C)			5:30		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10-03, 1953, to 2-27, 1956, that I last saw the deceased alive on 2-17, 1956, and that death occurred at 4:30 P.M. from the causes and on the date stated above. SIGNATURE W. Henry K. Gallagher					
ADDRESS (Street, city, town, state) M.D. Catonsville-287 M.					
DATE SIGNED 2-20-56					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORI		LOCATION (City, town, or county) (State)
Burial		7-1-56	M.D. Catonsville-287 M.		
24. REC'D. BY REGISTRAR DATE		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	
FEB 23 1956		T. E. Harry			

55

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01467

## 1497 CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

COUNTY BALTO.

MARYLAND

CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
OR and give nearest town) (in this place)

TOWN SPARROWS POINT (19) 30 YRS

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS RURAL ROUTE #302

BOX

3. NAME OF  
DECEASED:  
(First)

(Middle)

(Last)

WILBUR GEORGE KYLE

## 4. SEX:

M.

6. COLOR OR  
RACE:

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify):

MARRIED

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired)

WILLWRIGHT HELPER

10B. KIND OF BUSINESS  
OR INDUSTRY:

STEEL WORKER

## 13. FATHER'S NAME:

JOHN KYLE

18. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unk.) (If Yes, give war or dates  
of service)

No

## 16. SOCIAL SECURITY NO.

213-07-6675

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## IMMEDIATE CAUSE

(A)  
DUE TO

Cerebral Vascular Accident

INTERVAL BETWEEN  
ONSET AND DEATH

3 days.

## ANTECEDENT CAUSE (B)

(B)  
DUE TOHypertensive Arteriosclerotic Cardio-  
vascular Disease.

(C)

Senility

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

O

20. AUTOPSY?  
YES  NO 21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
While  Not while   
at work  at work 

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 6, 1956, to Feb. 27, 1956, that I last saw the deceased  
alive on Feb. 23, 1956, and that death occurred at 2 <sup>10</sup>/<sub>12</sub> A.M., from the causes and on the date stated above.  
SIGNATURE ADDRESS DATE SIGNED23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

BURIAL

## DATE THEREOF

2-27-56

## NAME OF CEMETERY OR CREMATORI

DAK DAWN

## LOCATION (City, town, or county)

BALTO. CO. MD.

(State)

DATE REC'D BY LOCAL  
REGISTRAR 1956

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

Walter L. Edwards, Walter Bush, Charles, M.D.

21. 10. 1911

21

1911

## 1498 CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH.

COUNTY BALTIMORE

MARYLAND

CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
OR and give nearest town) (in this place)

TOWN FORT HOWARD

87 Days

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

50 VETERANS ADMINISTRATION HOSPITAL

3. NAME OF  
DECEASED:  
(Type or Print)

JOSEPH (Juozapas) (MI)

(First)

(Middle)

(Last)

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MARYLAND

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN JESSUPS

STREET  
ADDRESS

(If rural give location)

Box 54

4. DATE (Month)  
OF  
DEATH

February 12

1956

## 5. SEX:

MALE

6. COLOR OR  
RACE:

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify):

Married

## 8. DATE OF BIRTH:

8-18-93

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life.  
even if retired):10B. KIND OF BUSINESS  
OR INDUSTRY:

Cement Finisher

## 9. AGE last birthday

62

yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

## 13. FATHER'S NAME:

Joseph Latvanas

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates  
of service) WW-I

Yes

## 16. SOCIAL SECURITY NO.

Unknown

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

## IMMEDIATE CAUSE

(A)

INFARCTION OF MYOCARDIUM DUE TO ARTERIO-

4 MONTHS

## ANTECEDENT CAUSE (S)

PREEXIST

SCLEROTIC CORONARY THROMBOSIS

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

4 YEARS

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

PULMONARY TUBERCULOSIS

38 YEARS

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES  NO 21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH21B. PLACE (Home, farm, factory  
OR INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year)  
OF INJURY21E. INJURY OCCURRED  
While  Not while   
at work  at work 

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 17, 1955, to Feb. 12, 1956, that he was in the deceased  
alive on ~~Nov. 17, 1955~~, and that death occurred at 9:00 AM, from the causes and on the date stated above.  
SIGNATURE *John C. Cook* ADDRESS *212-56* DATE SIGNED23. BURIAL, CREMATION, DATE THEREOF  
REMOVAL (SPECIFY)NAME OF CEMETERY OR CREMATORIUM LOCATION (C.ty. town, or county)  
B-15-56 Baltimore National Cemetery Baltimore, Maryland

(State)

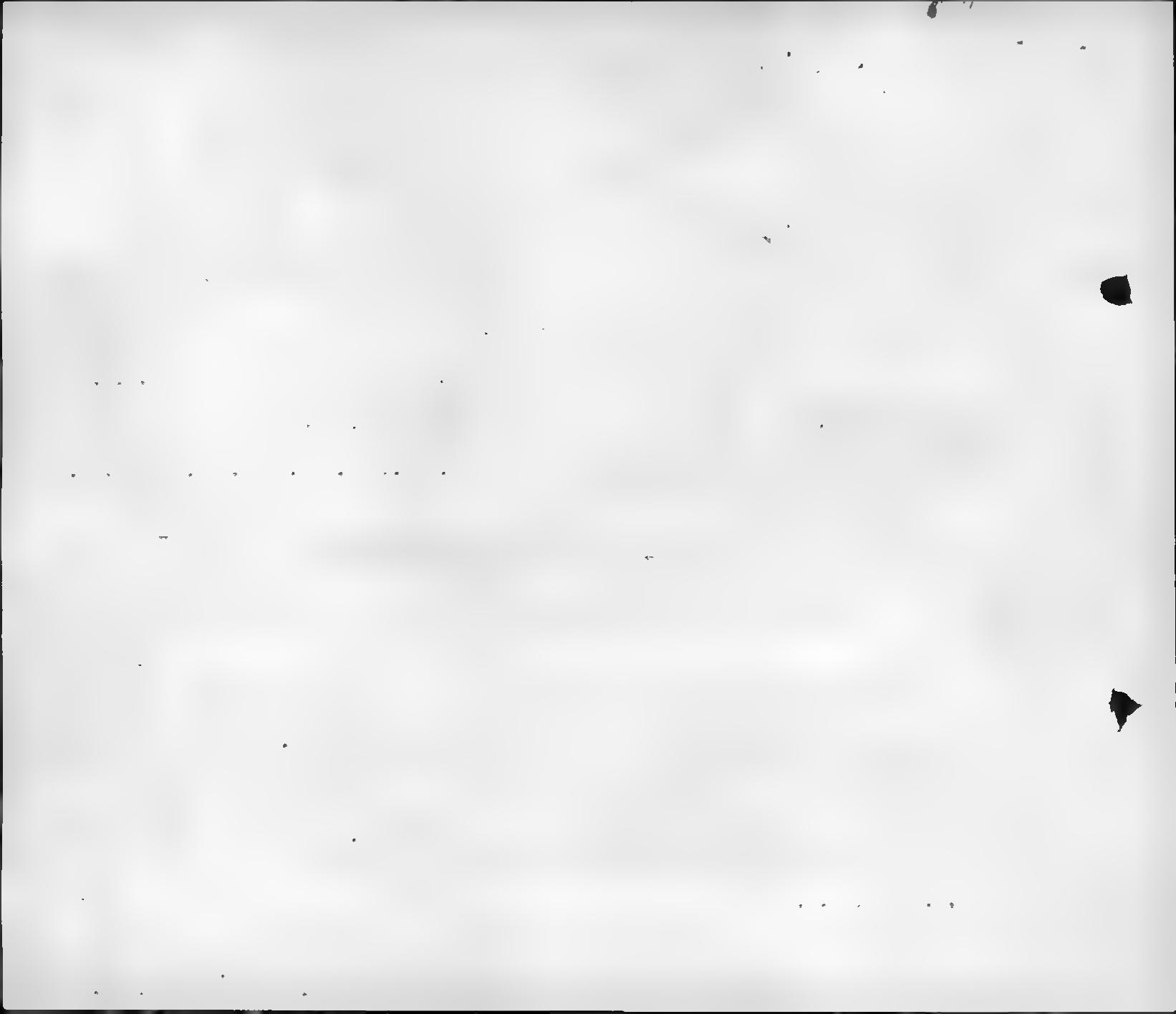
DATE REC'D BY LOCAL  
REGISTRAR

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

William Cook-Blight Inc. Funeral Home  
6009 Harford Ave., Baltimore 14, Md.

ADDRESS



## 1499 CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL or and give nearest town)  
 LENGTH OF STAY (in this place)  
 TOWN Chase, Md. LIFE

HOSPITAL OR INSTITUTION OR STREET ADDRESS Eastern Ave

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY Balto  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR TOWN Chase, Md.  
 STREET ADDRESS Eastern Ave (If rural give location)

## 3. NAME OF DECEASED: (First) (Middle) (Last)

Hate4. DATE (Month) (Day) (Year)  
Feb 6 1956

## 5. SEX:

6. COLOR OR RACE: white 7. SINGLE, MARRIED, WIDOWER, DIVORCED, (Specify): Widower 8. DATE OF BIRTH: Oct. 25 1866 9. AGE last birthday: 89 yrs.IF UNDER 1 YEAR IF UNDER 24 HRS.  
Months Days Hours Min.10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): housewife10b. KIND OF BUSINESS OR INDUSTRY: own home11. BIRTHPLACE (State or foreign country) Balto, Md.12. CITIZEN OF WHAT COUNTRY? U.S.A.13. FATHER'S NAME: John Reinhardt14. MOTHER'S MAIDEN NAME: Hate Haas15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no16. SOCIAL SECURITY NO.: None 17. INFORMANT & ADDRESS: Catherine Chenoweth3029 1/2 Chester Ave, Balt., 18Interval Between  
Onset And Death

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

100%

Immediate cause

Lobar Pneumonia1 day

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

atherosclerotic Cardiovascular disease2 yrs

(e)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, of office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
------------------------	--	----------------	----------	---------

TIME (Month) (Day) (Year)	(Hour)	INJURY OCCURRED OF INJURY	While at m. Work <input type="checkbox"/> At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
---------------------------	--------	---------------------------------	---	-----------------------

22. I hereby certify that I attended the deceased from Feb 2 1956, to Feb 6 1956, that I last saw the deceasedalive on Feb 6 1956, and that death occurred at 9 PM, from the causes and on the date stated above.SIGNATURE Mary Margarette M. D.

(Degree or title)

ADDRESS

DATE SIGNED 2/18/56

22. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify)	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)
--	---------------------------------	----------------------------------	---------

Burial <u>3/10/56</u>	St. Michaels Luth. <u>Balto.</u>	Md.
-----------------------	----------------------------------	-----

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
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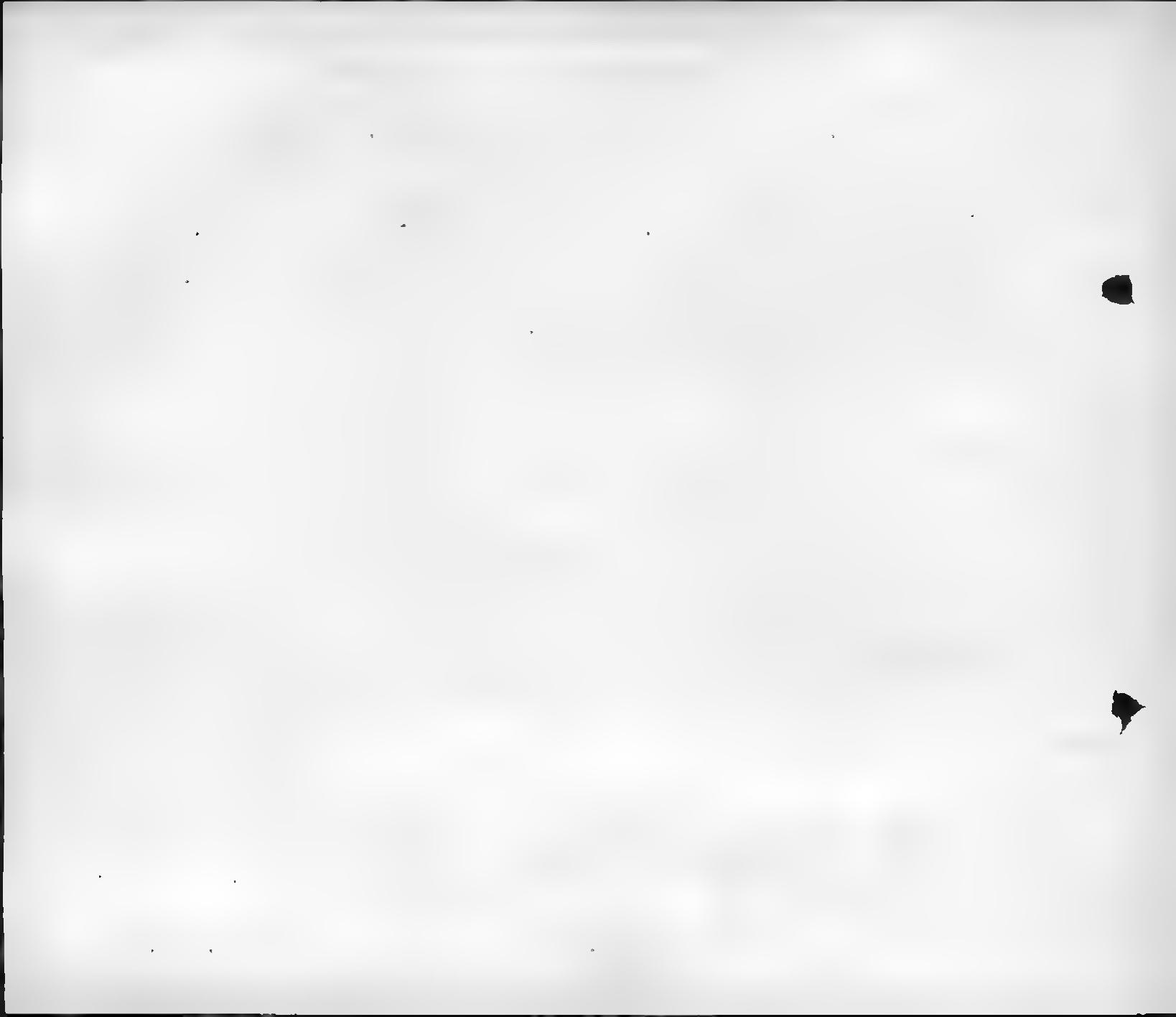
<u>Mar 9 1956</u>	<u>A. W. Hirsch</u>	<u>Lazarus Funeral Home</u>	<u>7401 Belair Rd.</u>
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## 1510 CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH: COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Md.</b> COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Catonsville</b>		LENGTH OF STAY (In this place)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>16 Fusting Ave.</b>		STREET ADDRESS <b>1656 Northgate Rd.</b>	
3. NAME OF DECEASED: (First) <b>CLARA</b> (Middle) <b>B.</b> (Last) <b>LEASE</b>		4. DATE (Month) (Day) (Year) <b>Feb. 18 1956</b>	
5. SEX: <b>female</b> COLOR OR <b>white</b> RACE: <b>white</b> 6. <b>SINGLE, MARRIED,</b> 7. <b>WIDOWED, DIVORCED.</b> (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Oct. 5, 1869</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>at home</b>	
13. FATHER'S NAME: <b>John Gwynn Tibbals</b>		11. BIRTHPLACE (State or foreign country): <b>Md.</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		18. SOCIAL SECURITY NO.	
19. INFORMANT & ADDRESS: <b>Mr. H. Gwynn Lease-1656 Northgate Rd.</b>		17. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		 <b>Myocardial Demyelination</b> <b>10da.</b>	
IMMEDIATE CAUSE <b>Antecedent Cause (8):</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(A) DUE TO <b>Cl. Hypertensive Cardio-Vascular Disease</b> <b>15 yrs.</b>	
		(B) DUE TO	
		(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <b>10-4, 1955</b> , to <b>2-18, 1956</b> , that I last saw the deceased alive on <b>2-18, 1956</b> , and that death occurred at <b>2:15 P.M.</b> from the causes and on the date stated above. SIGNATURE <i>John Gwynn Tibbals</i> ADDRESS <b>M. D Catonsville-282nd.</b> DATE SIGNED <b>2-20-56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>2/21/56</b> NAME OF CEMETERY OR CREMATORIUM <b>Mt. Olivet Cem.</b> LOCATION (City, town, or county) <b>Balto., Md.</b> (State)	
DATE REC'D BY LOCAL REGISTRAR <b>Feb. 20, 1956</b>		REGISTRAR'S SIGNATURE <b>G. H. Field</b> 24. FUNERAL DIRECTOR <b>Mr. J. Schlesinger &amp; Sons, Balt. 17th</b> ADDRESS	



15/1 MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Charlottesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Charlottesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>30 gas</u>	
3. NAME OF DECEASED (First) <u>EMMA</u> (Middle) <u>-ETTA</u> (Last) <u>-LEIGHT</u> (Type or Print)		4. DATE OF DEATH <u>Feb 14</u> 1956	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>April 13-1896</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house</u>		9. AGE last birthday <u>59</u> yr.	
10b. KIND OF BUSINESS OR INDUSTRY <u>house</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
13. FATHER'S NAME <u>John J. Myers</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		15. MEDICAL CERTIFICATION	
16. SOCIAL SECURITY NO. <u>MI</u>		17. INFORMANT AND ADDRESS <u>Elaine Leight, Charlottesville, Md</u>	
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  Immediate cause (a) <u>Coronary artery disease</u> Interval Between Antecedent cause(s) (b) <u></u> Onset and Death Disease or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) <u></u>			
19. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death <u>Varicose Veins.</u> 20 yrs.			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <u>None</u>		22. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u> m. INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/> HOW DID INJURY OCCUR? <u>None</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		24. DATE THEREOF <u>Feb 17/56</u> NAME OF CEMETERY OR CREMATORIY <u>Trinity</u> LOCATION (City, town, or county) <u>Bethel</u> (State) <u>Md</u>	
DATE REC'D BY LOCAL REG. <u>2-16-56</u>		25. FUNERAL DIRECTOR <u>Edw. Caples</u> ADDRESS <u>Hampstead Md</u>	
REG. <u>Mary B. Eline</u>			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1950-1951

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01472

## 1502 CERTIFICATE OF DEATH

Reg. Dist. No.

THIS IS A PERMANENT RECORD.  
PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.  
Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly. The  
THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Alice Louise Lennert		2/12/56	
3. PLACE OF DEATH: Annapolis, Md., Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution, residence A STATE Md	
5. FULL NAME OF HOSPITAL OR INSTITUTION		B COUNTY before admission)	
812 Register Ave		C CITY OR TOWN Balt	
6. LENGTH OF STAY IN BALTIMORE 1 mo.		D. STREET ADDRESS (If rural, give location) 5500 Lombardy Place	
7. SEX	8. COLOR OR RACE	9. SINGLED, MARRIED, WIDOWED, DIVORCED (Specify)	10. AGE (In years, last birthday)
Female	White	Widowed	73
11. OCAUATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY	
Housewife		U.S.A.	
13. FATHER'S NAME John Browne		14. MOTHER'S MAIDEN NAME Katherine Sloane	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Randolph McHenry		ADDRESS	
18. 1576		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death)		Carcinoma, Head of Pancreas with Jaundice	
ANTECEDENT CAUSES		INTERVAL BETWEEN ONSET AND DEATH 2 mo.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST		(B) Atherosclerotic Cardio- vascular Disease	
(C)		24 mos.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Cerebral Vascular Accident	
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22. I certify that (I) (the hospital) attended the deceased from... Dec. Feb. 1956, that (I) (we) last saw the deceased alive on... Feb. 10 and that death occurred at 10 A.M., from the causes and on the date stated above.		1956 to 1956	
23A. SIGNATURE Tom L. Kanner, M.D.		23B. ADDRESS 501 Sheridan Ave.	
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		23C. DATE SIGNED 2/13/56	
24A. BURIAL, CREMA- TION, REMOVAL (Specify) Burial		24B. DATE 2/15/56	
24C. NAME OF CEMETERY OR CREMATORIUM Woodlawn		24D. LOCATION (City, town, or county) Woodlawn, Md.	
DATE RECEIVED BY LOCAL REGISTRAR 2-14-56		REGISTRAR'S SIGNATURE S. W. Debrick	
		25. FUNERAL DIRECTOR ADDRESS 1217 St. Paul St.	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01473

## 1503 CERTIFICATE OF DEATH

Reg. Dist. No. 33

## 1. PLACE OF DEATH:

COUNTY **Baltimore** MARYLAND  
 CITY (If outside corporate limits, write RURAL  
 OR and give nearest town)  
 TOWN **Owings Mills** LENGTH OF STAY  
 (In this place) **2 yrs.**  
 HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS **Rosewood State Tr. School**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland** COUNTY **Prince Georges**  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN **Hyattsville**  
 STREET ADDRESS  
 (If rural give location)  
**8215-14th Avenue**

## 3. NAME OF (First) (Middle) (Last)

DECEASED: **Phillip**4. DATE (Month) (Day) (Year)  
 OF DEATH: **2 2 1956**5. SEX 6. COLOR OR 7. SINGLE, MARRIED,  
 RACE: WIDOWED, DIVORCED,  
 (Specify): **male white single** 8. DATE OF BIRTH:  
**6/29/53** 9. AGE last birthday  
 IF UNDER 1 YEAR  
 Months **2** Days **2** Hours **19** Min10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):  
**—** 10B. KIND OF BUSINESS OR INDUSTRY:  
**—**11. BIRTHPLACE (State or foreign country): **Washington, D.C.** 12. CITIZEN OF WHAT COUNTRY?  
**U.S.A.**

## 13. FATHER'S NAME:

**Leo Levine**

## 14. MOTHER'S MAIDEN NAME

**Shirley Breslow**15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  
**—**

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS:

**Rosewood Records**18. MEDICAL CERTIFICATION  
 I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  
**47/1**INTERVAL BETWEEN  
 ONSET AND DEATH  
**24 hrs.**

## IMMEDIATE CAUSE

(A)  
 DUE TO**Pneumonitis****Acute Bronchitis**  
**Bronch. pneumonia**

## ANTECEDENT CAUSE (B)

(B)  
 DUE TO**Hydrocephaly**

since birth

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  
**Malnutrition**

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
 YES  NO 21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

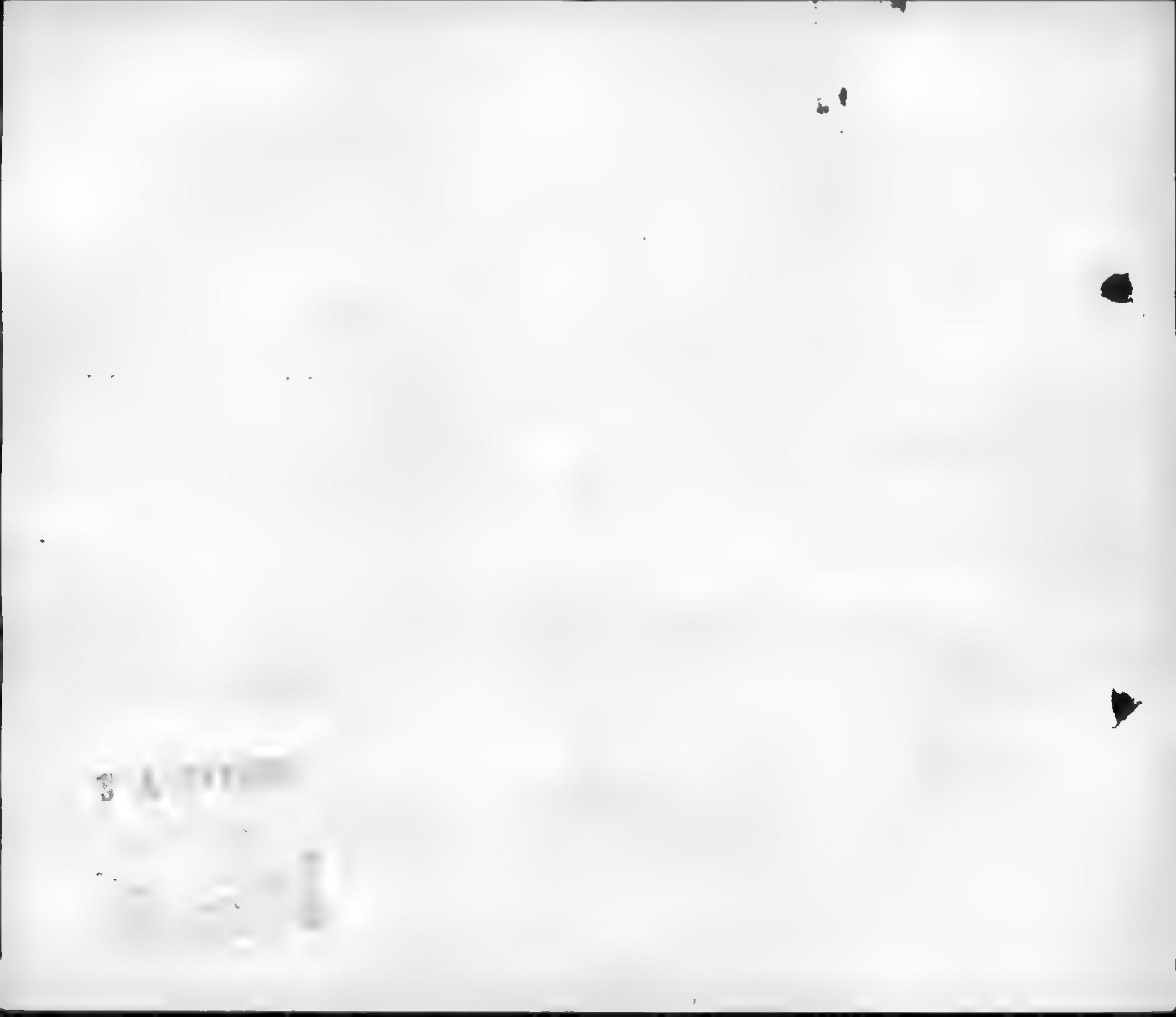
21C. WHERE DID INJURY OCCUR? (City or town)  
 (County) (State)21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 21E. INJURY OCCURRED WHILE  NOT WHILE   
 M. AT WORK  AT WORK 

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **2/1**, 19 56, to **2/2**, 19 56, that I last saw the deceased alive on **2/2**, 19 56, and that death occurred at **9:00** AM, from the causes and on the date stated above.  
 SIGNATURE **Mary B. Butler** ADDRESS **Hyattsville, Md.** DATE SIGNED **2/2/56**

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY) DATE THEREOF NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)

**2-2-56** **Mary B. Levine** **Goldberg Funeral Home** **4217 9th St NW** **Washington D.C.** **ADDRESS**  
**2-2-56** **Mary B. Levine** **Goldberg Funeral Home** **4217 9th St NW** **Washington D.C.** **ADDRESS**



01474

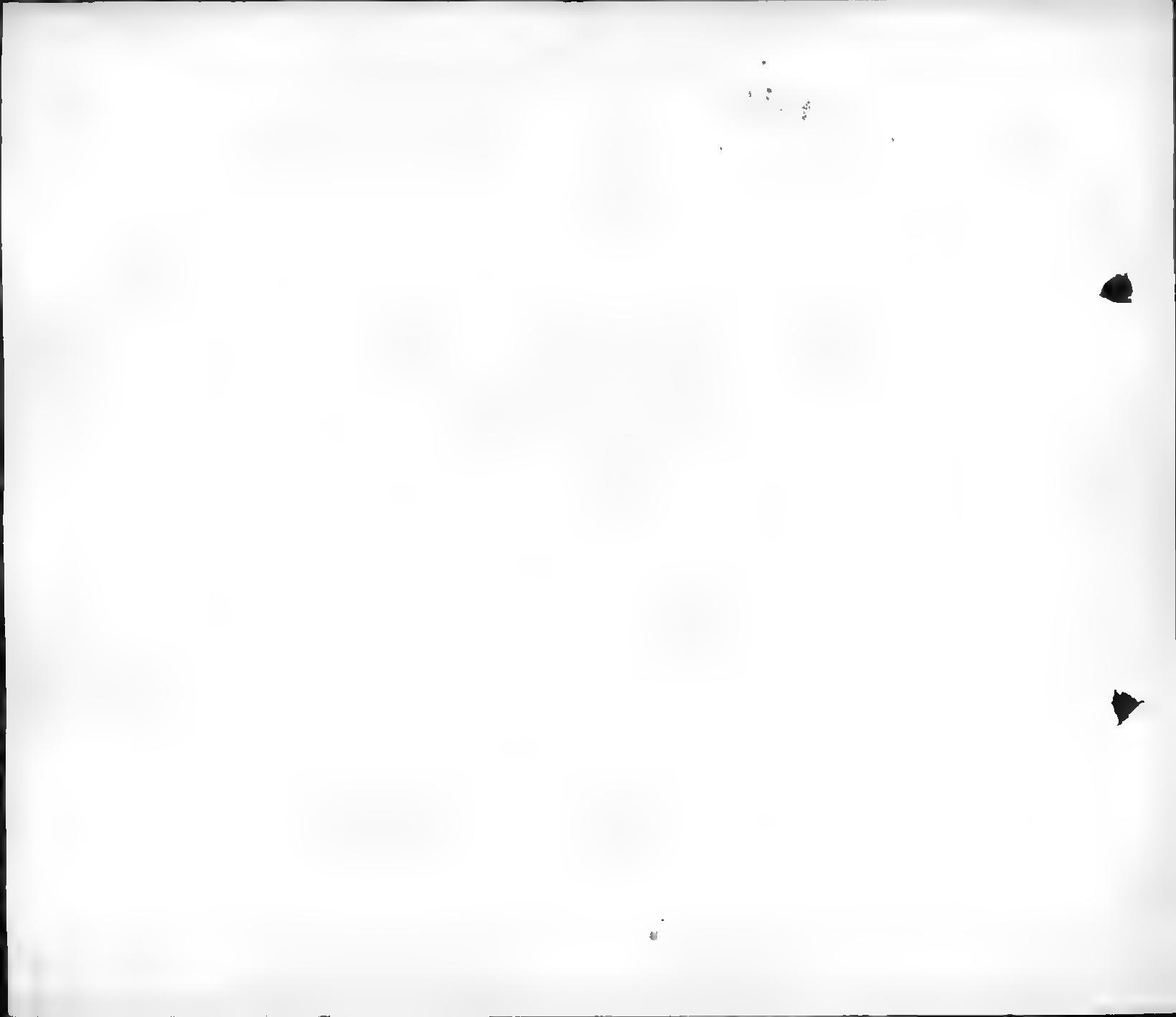
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, F-1a G-3 3-1-56 et

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH 152		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Brooke Parksville	LENGTH OF STAY (In this place) 15 years	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Pikesville 8 Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 20 Orchard Rd.	STREET ADDRESS Orchard Rd		(If rural give location)
3. NAME OF DECEASED: (Type or Print) Bridget Agnes Lingg	(First)	(Middle)	(Last)
4. DATE (Month) OF DEATH: 7th	(Day)	(Year)	1956
5. SEX: F	COLOR OR RACE: white	SINGLE, MARRIED. WIDOWED, DIVORCED Known	DATE OF BIRTH: 1885
10A. USUAL OCCUPATION (Give kind of work done during most of working life. even if retired): housewife	10B. KIND OF BUSINESS OR INDUSTRY: none	10C. AGE last birthday 70 yrs. 1 yr.	11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY: USA	13. FATHER'S NAME: Patrick Dougherty		
14. MOTHER'S MAIDEN NAME: Margaret Donnelly	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) yes		
16. SOCIAL SECURITY NO none	17. INFORMANT & ADDRESS: Benjamin Lingg, Orchard Rd. Pikesville 8 Md.		
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  IMMEDIATE CAUSE (A) _____ ANTECEDENT CAUSE (B) _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) _____  II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  III. INTRACRANIAL HEMORRHAGE DUE TO CIRRHOSIS OF LIVER			
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION			INTERVAL BETWEEN ONSET AND DEATH 3 mos.
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR?	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 28 Nov., 1955, to 14 Feb., 1956 that I last saw the deceased alive on 14 Feb., 1956, and that death occurred at 9:00 A.M. from the causes and on the date stated above. ADDRESS _____ DATE SIGNED _____ SIGNATURE Paul H. Royle			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Friday 17 1956	NAME OF CEMETERY OR CREMATORIAL Forest Glen Cemetery	LOCATION (City, town, or county) Pikesville, Maryland
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS Frank H. Powell, Pikesville	



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01475

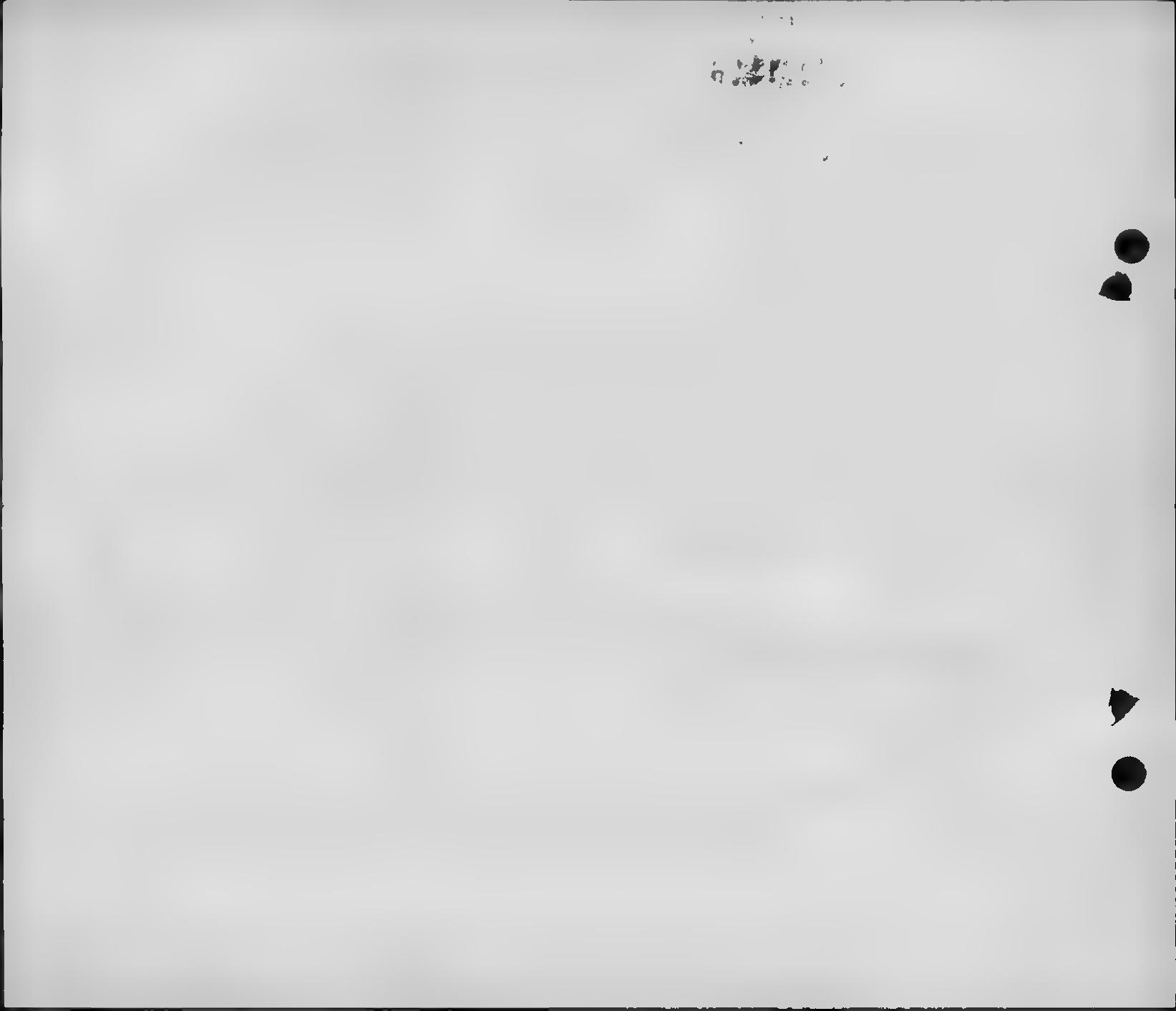
## 1505 CERTIFICATE OF DEATH

Reg. Dist. No. ....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Md.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Notch Cliff, near Towson</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Notch Cliff, Md. near Towson</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Villa Maria 8 Glenview Rd</i>		STREET ADDRESS <i>8 Glenview Rd</i>	
3. NAME OF DECEASED (Type or Print) <i>S. M. Cantalicia Magin</i>		4. DATE OF DEATH <i>Feb 26 1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH <i>April 7, 1869</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>RELIGIOUS.</i>	
13. FATHER'S NAME <i>Marvin Magin</i>		11. BIRTHPLACE (State or foreign country) <i>Rochester, N.Y.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <i>Mary Englebert</i>	
17. INFORMANT AND ADDRESS <i>Sr. Mary Clara NOTCH CLIFF NR Towson, MD.</i>		18. MEDICAL CERTIFICATION  I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  1505 Immediate cause (a)  Antecedent cause(s) Diseases or conditions, if any, (b) giving rise to the above cause stating the underlying cause last  (c)  Respiratory failure due to metastasis Carcinoma of ascending colon 1 week 5 yrs.	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19. DATE OF OPERATION	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, Farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept. 22, 1953, to Feb. 26, 1956, that I last saw the deceased alive on Feb. 21, 1956, and that death occurred at 12:50 P.M., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED <i>Charlotte Donnell, M.D.</i> 7501 York Rd. Towson, MD, 2-16-56.			
23. BURIAL, CREMATION REMOVAL (Specify) <i>BURIAL</i>		DATE THEREOF <i>2-28-56</i>	
DATE REG'D. BY LOCAL REG.		NAME OF CEMETERY OR CREMATORIAL <i>VILLA MARIA CEM.</i>	
REGISTRAR'S SIGNATURE <i>John Federl</i>		LOCATION (City, town, or county) (State) <i>NOTCH CLIFF NR Towson, MD.</i>	
REG.		24. FUNERAL DIRECTOR <i>John Federl</i>	
REG.		ADDRESS <i>901 S. Conklin St. BALTO. MD.</i>	



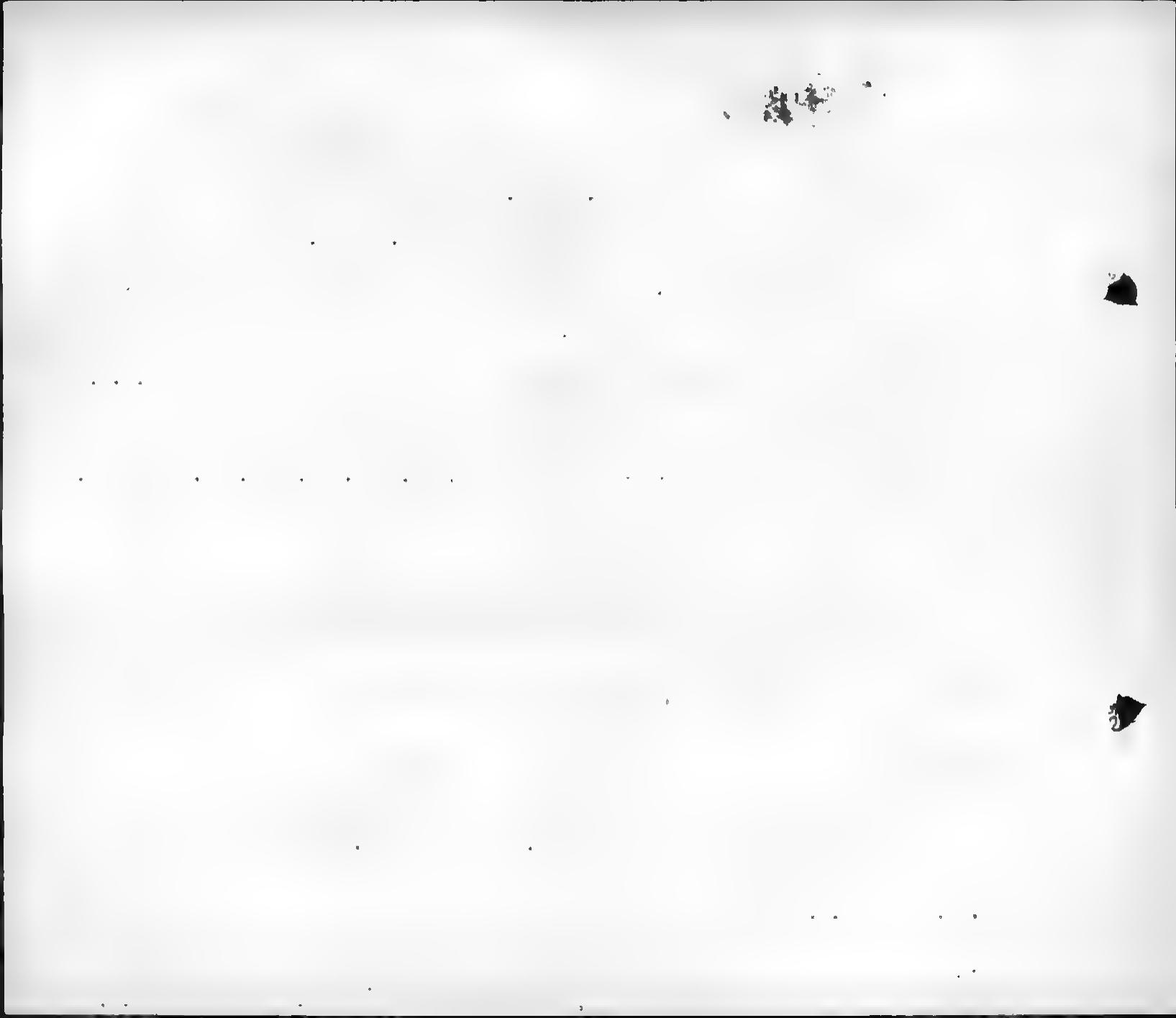
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01476

1506

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN FORT HOWARD		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural give location) Rt. #4, St. MARGARETTES	
3. NAME OF DECEASED: (Type or Print) AUGUST CARI MATTES		4. DATE (Month) (Day) OF DEATH February 10, 1956	
5. SEX MALE	6 COLOR OR RACE WHITE	7 SINGLE MARRIED WIDOWED, DIVORCED. (Specify): WIDOWED	8 DATE OF BIRTH 9-10-91
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Automobile	
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: CHRISTIAN MATTES		14. MOTHER'S MAIDEN NAME: HERMINE BREINING	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW-1		16. SOCIAL SECURITY NO. 213-01-9778	
17. INFORMANT & ADDRESS: Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE ANTECEDENT CAUSE (B)		(A) DUE TO APLASTIC ANEMIA (B) DUE TO (C)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		UNKNOWN	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? 5:00 PM		11:25 PM	
22. I hereby certify that <input checked="" type="checkbox"/> attended the deceased from Feb. 10, 1956, to Feb. 10, 1956, <input checked="" type="checkbox"/> attended and that death occurred at 11:25 PM, from the causes and on the date stated above. ADDRESS DATE SIGNED M.D. VAH, Fort Howard, Maryland 2-12-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 2/14/56	
DATE REC'D BY LOCAL REGISTRAR 2-3-56		NAME OF CEMETERY OR CREMATORIUM Baltimore National Cemetery	
REGISTRAR'S SIGNATURE John Peduzzi		LOCATION (City, town, or county) Baltimore, Maryland	
24. FUNERAL DIRECTOR Leonard J. Flick Funeral Home 5309 Harford Rd., Baltimore, Md.		ADDRESS	



## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01477

## 1507 CERTIFICATE OF DEATH

Reg. Dist. No. 37

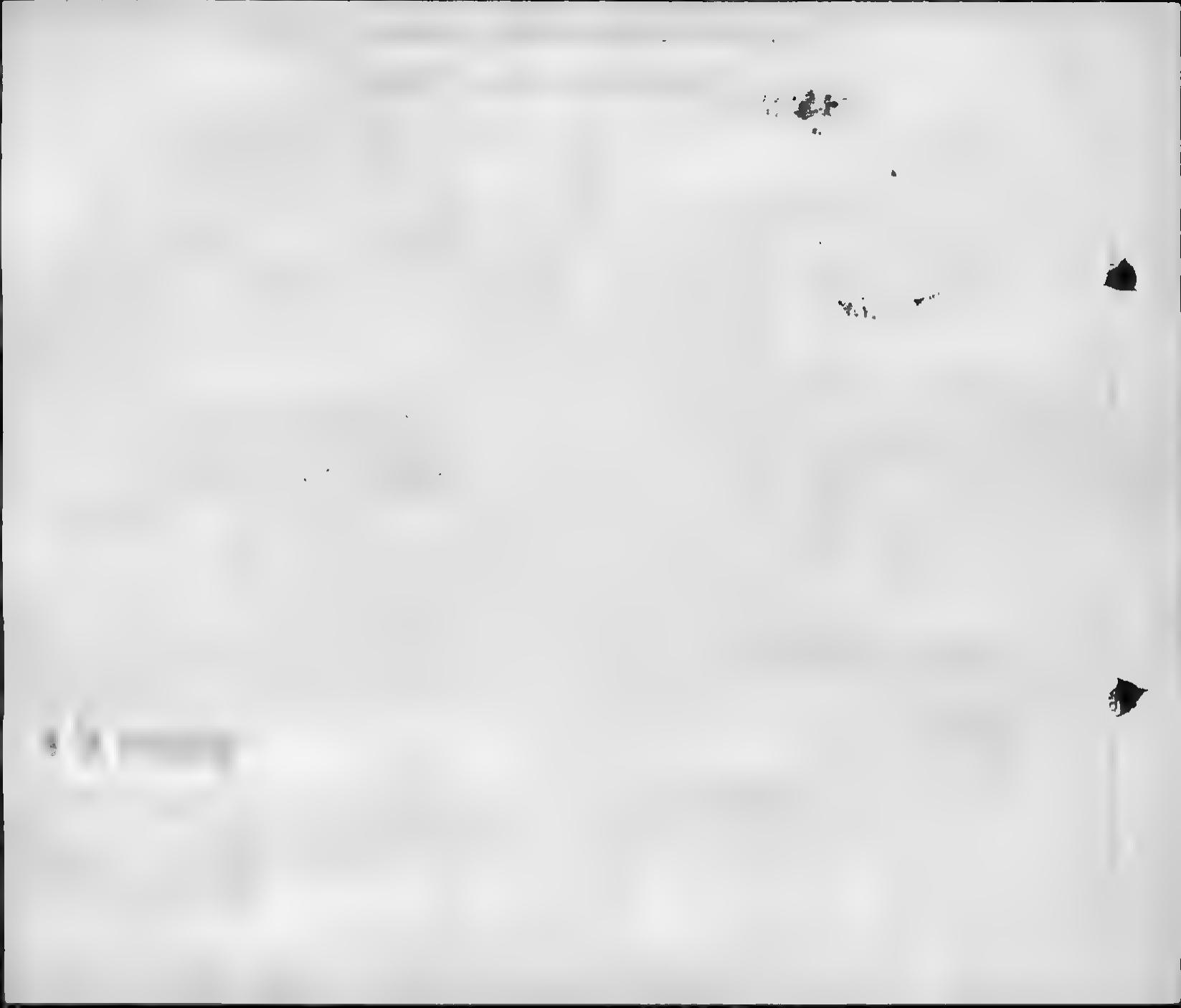
## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place) 12 years	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	MD. COUNTY Frederick
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location) Francis Scott Key Hotel		
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
(First)	(Middle)	(Last)	Feb. 7 1956
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Female	White		Dec. 15, 1867
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 88 yrs.
Clerical Worker			# UNDER 1 YEAR Months Deys Hours Min.
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY? U.S.	
Jacob Thomas Bowers		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS Frank L. Smith Jr. Cockeysville, Md.
			INTERVAL BETWEEN ONSET AND DEATH
18. MEDICAL CERTIFICATION			
II DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		IMMEDIATE CAUSE (A) <i>Coronary Occlusion</i>	
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb. 4, 1949, to Feb. 6, 1956, that I last saw the deceased alive on Feb. 6, 1956, and that death occurred at 9:35 A.M. from the causes and on the date stated above. SIGNATURE <i>Walter J. Keen</i> M.D. ADDRESS (Street, city, town, state) <i>Cockeysville, Md.</i> DATE SIGNED <i>2/7/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF 2/9/56	NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery Frederick Maryland
24. REC'D BY REGISTRAR DATE		REGISTRAR'S SIGNATURE <i>Frank Smith</i>	LOCATION (City, town, or county) (State) ADDRESS Wm. Cook, Inc., 1217 St. Paul St.
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 10A

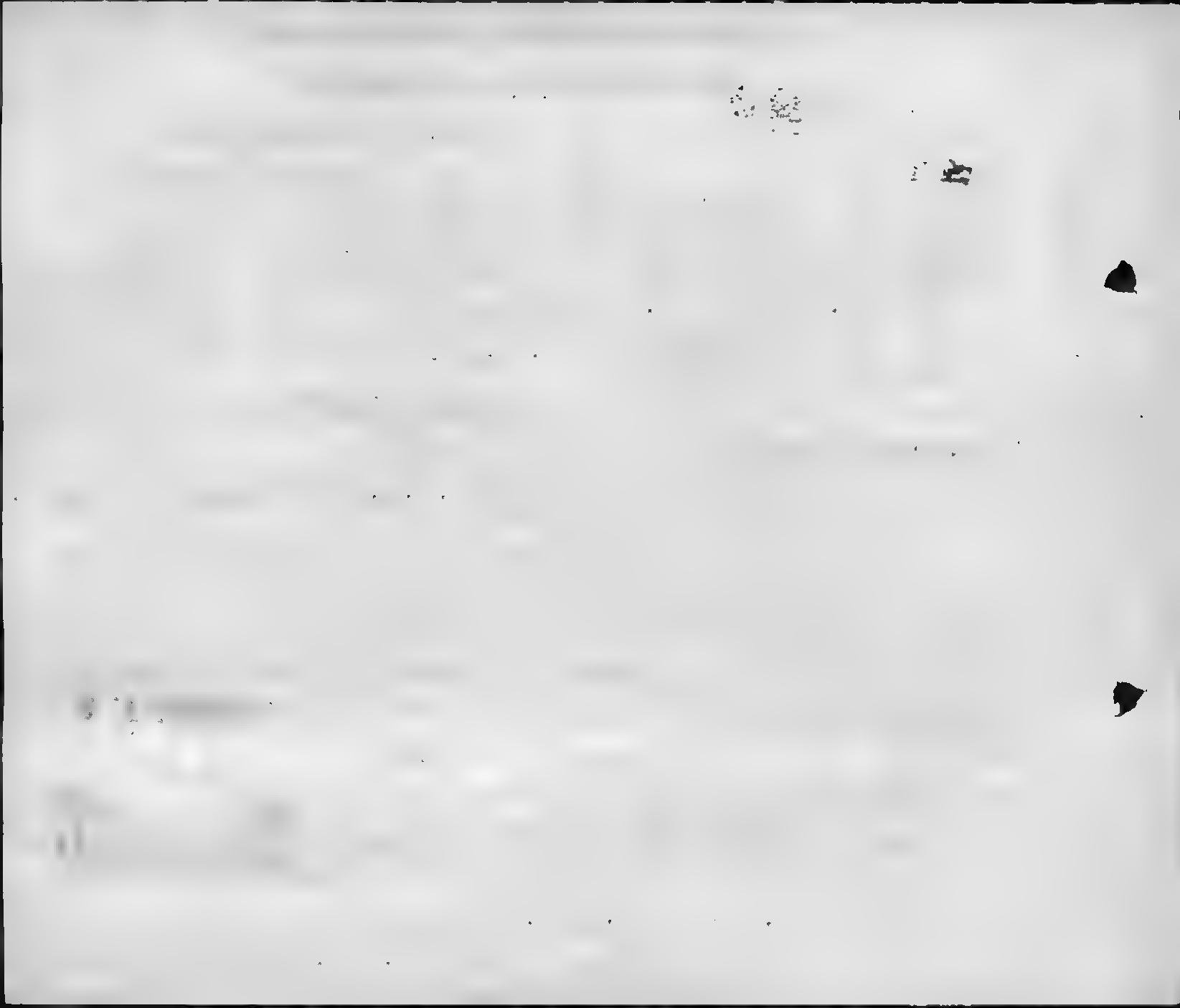
## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01478

## 1598 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED							
COUNTY		Baltimore MARYLAND		STATE		Maryland COUNTY Baltimore					
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		Rodgers Forge					
Rodgers Forge				Rodgers Forge							
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)							
245 Rodgers Forge Road				245 Rodgers Forge Road							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH							
Mrs. Marie S. Mc Call				February 1st 1956							
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.				
female	white	married	Aug. 26, 1893	62 yrs.	Months	Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
at home								Frederick Maryland			
13. FATHER'S NAME				14. MOTHER'S M AIDEN NAME							
Mr. Charles Snyder				Marie Gloyd							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.				17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)								Mr. E. J. Mc Call, 245 Rodgers Forge Rd.			
18. MEDICAL CERTIFICATION								INTERVAL BETWEEN ONSET AND DEATH			
Cause of Death Progression of disease on Anterior-lateral Boxes at an angle, 15°, 8 yrs.											
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				IMMEDIATE CAUSE (A)				ANTECEDENT CAUSE(S) DUE TO (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.											
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)				21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from ... to ..., 19 ..., that I last saw the deceased alive on ..., 19 ..., and that death occurred at ... A.M., from the causes and on the date stated above. SIGNATURE								ADDRESS (Street, city, town, state)		DATE SIGNED	
L. J. Mc Call, M.D.										2/4/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF				NAME OF CEMETERY OR CREMATORIUM			
Burial				Feb. 4th 1956				Mt. Marian Cemetery			
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE				LOCATION (City, town, or county) (State)			
								Towson, Maryland			
DATE								25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
								Leonard J. Ruck, 5305 Harford Road #14			



01479

STATE DEPARTMENT OF HEALTH

MARYLAND

## 13.99 CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH: COUNTY			2. USUAL RESIDENCE (HOME) OF DECEASED: STATE		
Baltimore MARYLAND			Maryland COUNTY Baltimore		
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)		
X TOWN Kingsville			X TOWN Kingsville		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS		
Hilltop Drive			Hilltop Drive		
3. NAME OF DECEASED (First) (Middle)			4. DATE (Last) (Month) (Day) (Year)		
Mrs. Mamie L.			Mc Cann February 18th 1956		
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	
female		white			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		
			at home		
13. FATHER'S NAME Mr. Howard Streett			14. MOTHER'S MAIDEN NAME Jane Campbell		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS Mrs. Mildred Roeder, Hilltop Dr. Kingsville	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
443K Immediate cause (a) ... Congestive Heart Failure							3 hrs.
Antecedent cause(s) (b) ... Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last						Hypertension Cardio vascular Disease	10 yrs. +
(c) ...							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY?	
						Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)	(COUNTY) (STATE)
INJURY							
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED at		How did injury occur?			
OF INJURY		m. While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>					

22. I hereby certify that I attended the deceased from April 1, 1955, to Feb. 18, 1956, that I last saw the deceased alive on Feb. 18, 1956, and that death occurred at 2:30 p.m., from the causes and on the date stated above.						
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED
William A. Tyson M.D.				Ringsville, Md.		Feb. 18, 1956
23. BURIAL, CREMATION REMOVAL (Specify)		DATE	NAME OF CEMETERY OR CREMATORIUM	LOCATION (City, town, or county)		(State)
Burial		Feb. 21, 1956	Waters Memorial Cemetery	Cooptown, Maryland		
DATE REC'D BY LOCAL REG.		REG. NO.	REG. NO.	24. FUNERAL DIRECTOR	ADDRESS	
				Leonard J. Ruck, 5305 Harford Road #14		

Dt. Tyson  
Kingsville, Md.  
Belair Rd. at main intersection.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01480

1510

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH.

COUNTY BALTIMORE

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)LENGTH OF STAY  
(in this place)

TOWN FORT HOWARD

13 Days

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

VETERANS ADMINISTRATION HOSPITAL

## 3. NAME OF DECEASED: (First) (Middle) (Last)

JOHN O. MC CRACKEN

(Type or Print)

MALE

WHITE

RACE:

6 COLOR OR  
7 MARRIED  
WIDOWED, DIVORCED.

(Specify)

MARRIED

10A USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired.)

Operator

10B KIND OF BUSINESS  
OR INDUSTRY

Motion Pictures

11. DATE OF BIRTH:

March 18, 1895

12. AGE last birthday

60

13. FATHER'S NAME:

George McCracken

14. MOTHER'S MAIDEN NAME:

Dora Reinich

15. INFORMANT &amp; ADDRESS:

Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.

16. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

17. IMMEDIATE CAUSE

ANTECEDENT CAUSE (B):

DISEASES OR CONDITIONS, IF ANY,

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST.

18. CARCINOMA OF LARYNX

(A) DUE TO

(B) DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING

TO THE DEATH BUT NOT RELATED TO THE

DISEASE OR CONDITION CAUSING DEATH

HYPERTENSIVE CARDIOVASCULAR DISEASE

19A. DATE OF OPERATION.

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING  CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory  
street, office bldg., etc.)

21C. WHERE DID (City or town)

INJURY OCCUR?

(County) (State)

21D. TIME (Month) (Day) (Year) (Hour)

OF INJURY

21E. INJURY OCCURRED

While  Not while at work  at work 

21F. HOW DID INJURY OCCUR?

M.

VA

22. I hereby certify that I attended the deceased from Feb. 2, 1956, to Feb. 15, 1956

and that death occurred at 2:05A.M. from the causes and on the date stated above.

SIGNATURE

F.G. Dickey, M.D., Chief, Medical Service

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL

REGISTRAR

REGISTRAR'S SIGNATURE

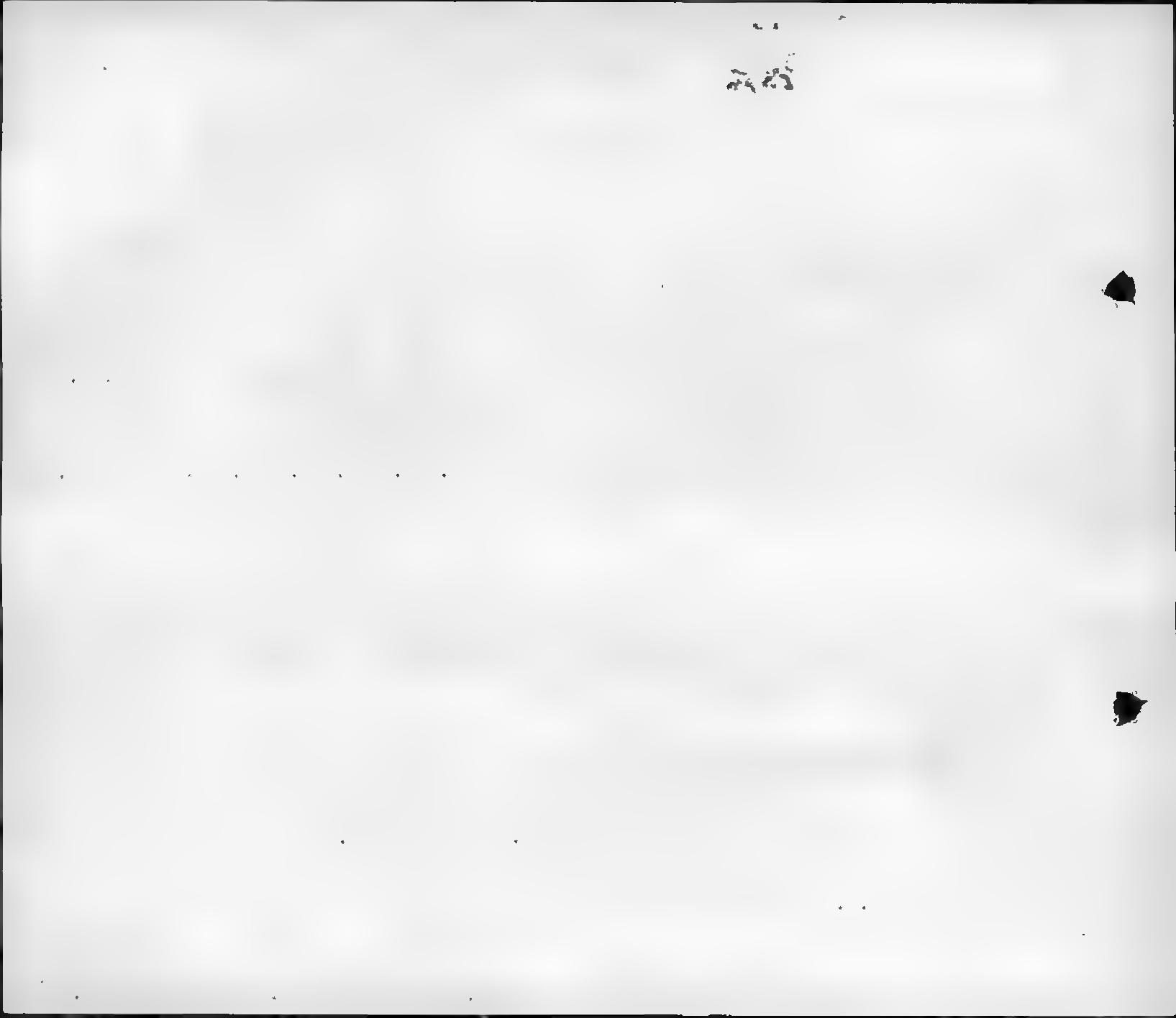
24. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Blight, Inc.

6009 Harford Rd.

Md.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

01481  
38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 522 Windwood Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
3. NAME OF DECEASED (Type or print) Mr. Dwight I. Mc Kay		First Middle Last	4. DATE OF DEATH Month Day Year February 27th 1956
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov 25, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Emp. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Connecticut	
10c. FATHER'S NAME Albert L. Mc Kay		11. BIRTHPLACE (State or foreign country) Elizabeth Mc Arthur	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Charles Robinson, 522 Windwood Road.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) L41X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Chronic bronchitis and asthma (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. p.m. p.m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-22</u> , 1956, to <u>2-27</u> , 1956, that I last saw the deceased alive on <u>2-27-56</u> 19 <u>19</u> , and that death occurred at <u>10:30</u> A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) William G. Helfreich, M.D., 5906 Roland Ave., Balt. 10 Md.	
ACTUAL SIGNATURE		DATE SIGNED	
PHYSICIAN'S NAME (Type) William G. Helfreich, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 1, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Brookfield Central Cem.	22d. LOCATION (City, town, or county) (State) Danbury, Connecticut
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Harford Road #14		24a. RECEIVED BY REGISTRAR DATE <u>Feb. 29, 1956</u>	
		24b. REGISTRAR'S SIGNATURE Mabel Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use of the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11/11/56

11/11/56

## 1512 CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Baltimore MARYLAND Catonsville LENGTH OF STAY (in this place) 4 years	STATE CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	Maryland COUNTY Calvert Mt. Wilson STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital				
3. NAME OF DECEASED: (Type or Print)	(First) George	(Middle) W.	(Last) Mennett	
4. DATE (Month) OF DEATH: Feb. 25	(Day) 19	(Year) 56		
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLED, MARRIED, WIDOWED, DIVORCED. (Specify): Single	8. DATE OF BIRTH: Jan. 5, 1880	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Odd Jobs	10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday 76 yrs.	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Charles Mennett	14. MOTHER'S MAIDEN NAME: Catherine Boyd			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS: Records: Spring Grove State Hospital		
18. MEDICAL CERTIFICATION				
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				
IMMEDIATE CAUSE	(A) DUE TO	Acute myocardial infarction 4 hours		
ANTECEDENT CAUSE (B)	(B) DUE TO	Arteriosclerotic coronary thrombosis ?		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(C)	Generalized arteriosclerosis years		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID (City or town) INJURY OCCUR?	(County)	(State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 2-15-1953 to 2-25-1956, what I last saw the deceased alive on 2-25-1956, and that death occurred at 9:00 AM, from the causes and on the date stated above.				
SIGNATURE <i>Frank E. Edwards</i> ADDRESS DATE SIGNED 2-25-56				
23. BURIAL, CREMATION, REMOVAL (SPECIFY): burial	DATE THEREOF Feb. 28, 1956	NAME OF CEMETERY OR CREMATORIUM SPRING GROVE STATE HOSP.	LOCATION (City, town, or county) Catonsville 28, Maryland	(State)
DATE REC'D BY LOCAL REGISTRAR <i>1/25/56</i>	REGISTRAR'S SIGNATURE <i>T.E. Edwards</i>	24. FUNERAL DIRECTOR ADDRESS SPRING GROVE STATE HOSPITAL - Catonsville 28, Maryland		

REGELVÉ  
LIBRARY

FEB 29 1956

LIBRARY

## 1513 CERTIFICATE OF DEATH

Reg. Dist. No. 35

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
 OR and give nearest town) (in this place)  
 TOWN Baltimore  
 HOSPITAL OR LENGTH OF STAY  
 INSTITUTION OR Cotton Ridge Nursing Home  
 STREET ADDRESS Harlem Lane

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN Baltimore City

STREET (If rural give location)  
 ADDRESS 1568 W. Fairmount Ave.3. NAME OF  
DECEASED:  
(Type or Print)

4. SEX

(First) Hattie (Middle) - Meyer (Last)5. COLOR OR  
RACE:6. 7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify): Widowed8. DATE OF BIRTH:  
Aug. 3, 187610a. USUAL OCCUPATION Give kind of  
work done during most of working life.  
(Even if retired):10b. KIND OF BUSINESS OR  
INDUSTRY: At Home11. BIRTHPLACE (State or foreign country): Maryland

## 13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service) No

16. SOCIAL SECURITY NO.:

17. INFORMANT &amp; ADDRESS:

Annie Smith - 1568 W. Fairmount Ave.Interval Between  
Onset And Death  
1 week

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Bronchitis pneumonia

DUE TO

## Antecedent causes (s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last.

(b) ...

DUE TO

(c) ...

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes No Review of abdomen. 2) Ascending peritonitis21. ACCIDENT (Specify) PLACE (Home, farm, factory, street,  
SUICIDE OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)  
HOMICIDE

TIME (Month) (Day) (Year)	(Hour)	INJURY OCCURRED While at Work <input type="checkbox"/>	Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
TIME (Month) (Day) (Year)	(Hour)	INJURY OCCURRED While at Work <input type="checkbox"/>	Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 19, 1956 to Feb. 2, 1956 that I last saw the deceased  
alive on Feb. 19, 1956, and that death occurred at 102 W. Fairmount Ave. from the causes and on the date stated above.  
SIGNATURE Jeff Coley (Degree or title) Mr. ADDRESS 4605 Edgewater Ave. 2/3/56 DATE SIGNED

23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR Crematory LOCATION (City, town, or county)  
REMOVAL (Specify) Burial (State) Baltimore - Md.

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE Feb. 6, 1956 FEDERAL DIRECTOR ADDRESS  
REGISTRAR Frederick H. Higginbotham 1300 Eutaw Place



## MARYLAND STATE DEPARTMENT OF HEALTH

01484

1514

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Baltimore</b> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <b>Catonsville</b>		LENGTH OF STAY (in this place) <b>27 years</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Spring Grove State Hosp.</b>		STREET ADDRESS <b>430 Sanders St.</b>		(If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <b>Raymond</b>	(Middle) <b>P.</b>	Last <b>Michael</b>	4. DATE OF DEATH <b>Feb. 17, 1956</b>	(Month) (Day) (Year)
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Apr 15 '98</b>	9. AGE last birthday <b>57</b> yrs.	11 under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seaman</b>		10b. KIND OF BUSINESS OR INSTITUTION <b>Merchant Marine</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>V. William Michael</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Marburger</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT AND ADDRESS <b>Records: Spring Grove State Hospital</b>		

## 18. MEDICAL CERTIFICATION

INTERVAL BETWEEN  
ONSET AND DEATH

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) **Congestive heart failure**Antecedent cause(s) (b) **Regurgitated food in bronchus**Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death**Tumor fourth ventricle**

?

## 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  Yes  No21. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING  CAUSE OF DEATHPLACE (Home, farm, factory, street,  
of office bldg., etc.)  
**Applie**

(CITY OR TOWN)

(COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURY **2/17/56 4:30 p.m.**INJURY OCCURRED  
While at Not while  
work  at work 

HOW DID INJURY OCCUR?

**Regurgitated food during meal**22. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes  accident  suicide  homicide  undetermined .

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

**2/18/56**23. BURIAL, CREMATION  
REMOVAL (Specify) **Burial**DATE THEREOF **2/21/56**

NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county) (State)

DATE REC'D. BY LOCAL REGISTRAR'S SIGNATURE **Feb 26/56 C. W. Hedding**

24. FUNERAL DIRECTOR

ADDRESS

**Wm. J. Lickner & Sons - Balt.****17, Md.**



1515

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

## 1. PLACE OF DEATH.

COUNTY Balto

MARYLAND

CITY (If outside corporate limits, write RURAL  
DR and give nearest town)TOWN Balto Co. MdLENGTH OF STAY  
(in this place)

50 yrs

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

4306 Kenwood Ave

3. NAME OF  
DECEASED:  
(Type or Print)

(First)

(Middle)

(Last)

4. DATE (Month)  
OF  
DEATH

(Year)

Feb

3

1956

## 5. SEX

6. COLOR OR  
RACE:7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify):

## 8. DATE OF BIRTH:

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired):10B. KIND OF BUSINESS  
OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT  
COUNTRY?

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates  
of service)

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS:

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## IMMEDIATE CAUSE

## ANTECEDENT CAUSE (S)

## DISEASES OR CONDITIONS, IF ANY,

## GIVING RISE TO THE ABOVE CAUSE

## STATING UNDERLYING CAUSE LAST.

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES  NO 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING  CAUSE OF INJURY

## (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21B. PLACE (Home, farm, factory,

## OF INJURY street, office bldg., etc.)

## 21C. WHERE DID (City or town)

## INJURY OCCUR?

## (County) (State)

## 21D. TIME (Month) (Day) (Year) (Hour)

## OF INJURY

## M.

## 21E. INJURY OCCURRED

While  Not while at work  at work 

## 21F. HOW DID INJURY OCCUR?

## ADDRESS

## DATE SIGNED

## 22. I hereby certify that I attended the deceased from

## June, 1947, to Feb 3, 1956, that I last saw the deceased

## alive on Feb 2, 1956, and that death occurred at 9:35 P.M.

## from the causes and on the date stated above.

## SIGNATURE

## ADDRESS

## DATE REC'D BY LOCAL

## REGISTRAR

## DATE REC'D BY LOCAL

D. English.

31.4

5 A (1720)

31

1720

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN** On HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 155 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01486

## 1516 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town)	MARYLAND LENGTH OF STAY (In this place)	STATE MARYLAND COUNTY CITY (If outside corporate limits, write RURAL end give nearest town)	STREET ADDRESS (If rural give location)
2 Baltimore TOWN EATONSVILLE HOSPITAL OR INSTITUTION OR STREET ADDRESS House in The Pines	30 days Nursing Home	Baltimore	605 MONASTERY Ave.
3. NAME OF (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH Feb. 27 1956	
Female	MARY C. Miller	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Hours Min
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Aug. 17, 1906
9. AGE last birthday 49 yrs.	10. KIND OF BUSINESS OR INDUSTRY		
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME William M. Miller		14. MOTHER'S MAIDEN NAME Amanda Elen McComas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-07-1712	
17. INFORMANT & ADDRESS Mr. E. P. Miller (29)		18. MEDICAL CERTIFICATION General Carenomatisis Carcinoma of Rectum	
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		20. INTERVAL BETWEEN ONSET AND DEATH Jan 1956 9 1/2 years	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19e. DATE OF OPERATION		19f. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M. et work		21f. HOW DID INJURY OCCUR? While Not while at work at work	
22. I hereby certify that I attended the deceased from (if 19. 1956) to (if 27. 1956), that I last saw the deceased alive on (if 25. 1956), and that death occurred at (if 115 P.M. from the causes and on the date stated above. SIGNATURE E. P. Miller			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3/1/56	
24. REC'D BY REGISTRAR FEB		REGISTRAR'S SIGNATURE J. E. Harry	
25. FUNERAL DIRECTOR'S SIGNATURE S. Truman Schatz		ADDRESS 3512 7 redwood St. (97)	
LOCATION (City, town, or county) BALTO. MARYLAND		(State)	



## MARYLAND STATE DEPARTMENT OF HEALTH

01487

2411 N. Charles Street, Baltimore

1517

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY		1517 (Baltimore) MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE		New York	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural, give location)	
3. NAME OF DECEASED (Type or Print)		(First) William	(Middle) Henry	(Last) Mills	4. DATE OF DEATH	2	(Month) 19
5. SEX		6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	11 under 1 year Months	11 under 24 hrs. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME		Book Binder		Durham N.C.		U.S.A.	
14. MOTHER'S MAIDEN NAME		Valerie Weaver					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS		18. MEDICAL CERTIFICATION	
yes		242-39-6375		Candell Mills 35 Marion St Brooklyn		Fracture of skull 20 to Auto Accident	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) Fracture of skull 20 to							
Antecedent cause(s) (b) Auto Accident							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
INJURY		TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Work At work		HOW DID INJURY OCCUR?	
OF INJURY		an.					
22. I hereby certify that I <del>certified</del> the deceased from 20-52 at 6:30 a.m. to 19 to 19, that I last saw the deceased							
alive on 19, and that death occurred at 6:30 a.m., from the causes and on the date stated above.							
SIGNATURE (Degree or title) ADDRESS DATE SIGNED							
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIAL		LOCATION (City, town, or county) (State)	
Burial		2/11/56		Long Island Natl Cem Long Island N.Y.			
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE				24. FUNERAL DIRECTOR		ADDRESS	
REG				Hedrick Holland Funeral Home		1631 Grand Hill Ave.	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01488

33

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Hall		c. LENGTH OF STAY IN 1b 25 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Hall	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hunters Mill Rd.			d. STREET ADDRESS Hunters Mill Rd.		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Sarah Elizabeth Powell Molock		First	Middle	Last	4. DATE OF DEATH 2-28-56
5. SEX female	6. COLOR OR RACE negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2-7-1879	9. AGE (In years lost birthday) 77 yrs
10a. USUAL OCCUPAT. ON (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Isaac			14. MOTHER'S MAIDEN NAME Laura ??		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO none		17. INFORMANT Howard Molock, White Hall Md.	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility			INTERVAL BETWEEN ONSET AND DEATH 24 hours		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>50</u> , 19 <u>54</u> , to <u>Feb 28</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Feb 23</u> , 19 <u>56</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Wm. Bortner</i> M.D.			ADDRESS (Street, city or town, state) <u>White Hall, Md.</u> DATE SIGNED <u>3-6-56</u>		
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-3-56		22c. NAME OF CEMETERY OR CREMATORIAL Stephenson A.M.E.	
22d. LOCATION (City, town, or county) Sparks, Md.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Scott Brooks</i>			24a. REC'D BY REGISTRAR DATE 3-6-56		24b. REGISTRAR'S SIGNATURE <i>Associate in Medicine</i>

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS A15 (4)  
15M 9/55

is a coming

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this bottom copy may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10W

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01489

## 1519 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place) 4 YRS.	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY MD DALTO.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 8411 LOCH RAVEN BLVD.	STREET ADDRESS 8411 LOCH RAVEN BLVD.	(If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) Rose ALBERT MUELLER		4. DATE OF DEATH 2-6-1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, SPOILED	8. DATE OF BIRTH Nov 22, 1879
9. AGE last birthday 76 yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME FRANCIS ALBERT		14. MOTHER'S MAIDEN NAME MADELINE WHISTLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT & ADDRESS MRS WM. A. BOWLING 8411 LOCH RAVEN BLVD.		18. MEDICAL CERTIFICATION Coronary Thrombosis.	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) DUE TO ANTECEDENT CAUSE(S) (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2/6/56, 19, to 19, that I last saw the deceased alive on 2/6/56, 19, and that death occurred at 3:30 P.M. from the causes and on the date stated above. SIGNATURE Denis J. McGrath			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 2/8/56	
NAME OF CEMETERY OR CREMATORIAL NEW CATHEDRAL		LOCATION (City, town, or county) BALTIMORE MD.	
24. REC'D BY REGISTRAR REG. NO. 1010 DATE 10/10/56		REGISTRAR'S SIGNATURE Mabel Gray	
25. FUNERAL DIRECTOR'S SIGNATURE Henry J. Jenkins Jr. C. 4905 YORK RD.		ADDRESS	



## CERTIFICATE OF DEATH

Reg. Dist. No.....

1520

## 1. PLACE OF DEATH:

Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)LENGTH OF STAY  
(in this place)

TOWN Redwood Md

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESSSorrenson nursing  
home3. NAME OF  
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

ELIZABETH R. Murphy

## 5. SEX:

6. COLOR OR  
RACE

Female

White

10a. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired):10b. KIND OF BUSINESS OR  
INDUSTRY:

house wife

11. BIRTHPLACE (State or foreign country):

Md.

79

9. AGE last birthday:

IF UNDER 1 YEAR

Months

Days

Hours

Min.

yrs.

12. CITIZEN OF WHAT  
COUNTRY?

## 13. FATHER'S NAME:

Patrick Doyle

## 14. MOTHER'S MAIDEN NAME:

Bridget Kiernan

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unk.)

(If Yes, give war or dates of  
service)

16. SOCIAL SECURITY NO.:

17. INFORMANT &amp; ADDRESS:

Catherine Elliott 5304 Barbara St.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN  
ONSET AND DEATH11  
Immediate cause (a).....  
DUE TOAntecedent cause(s)  
Diseases or conditions, if any,  
giving rise to the above cause  
stating underlying cause last  
(b).....  
DUE TO  
(c).....

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not  
related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes  No 21. ACCIDENT (Specify) PLACE (Home, farm, factory, street,  
SUICIDE OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)22. TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED  
OF INJURY M. While at Not while  
work at work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased

alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

23. BURIAL, Cremation  
REMOVAL (Specify): DATE THEREOF NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR ADDRESS

DATE REC'D BY LOCAL REG. DATE REC'D BY LOCAL REG.

REG. DATE REC'D BY LOCAL REG. DATE REC'D BY LOCAL REG.

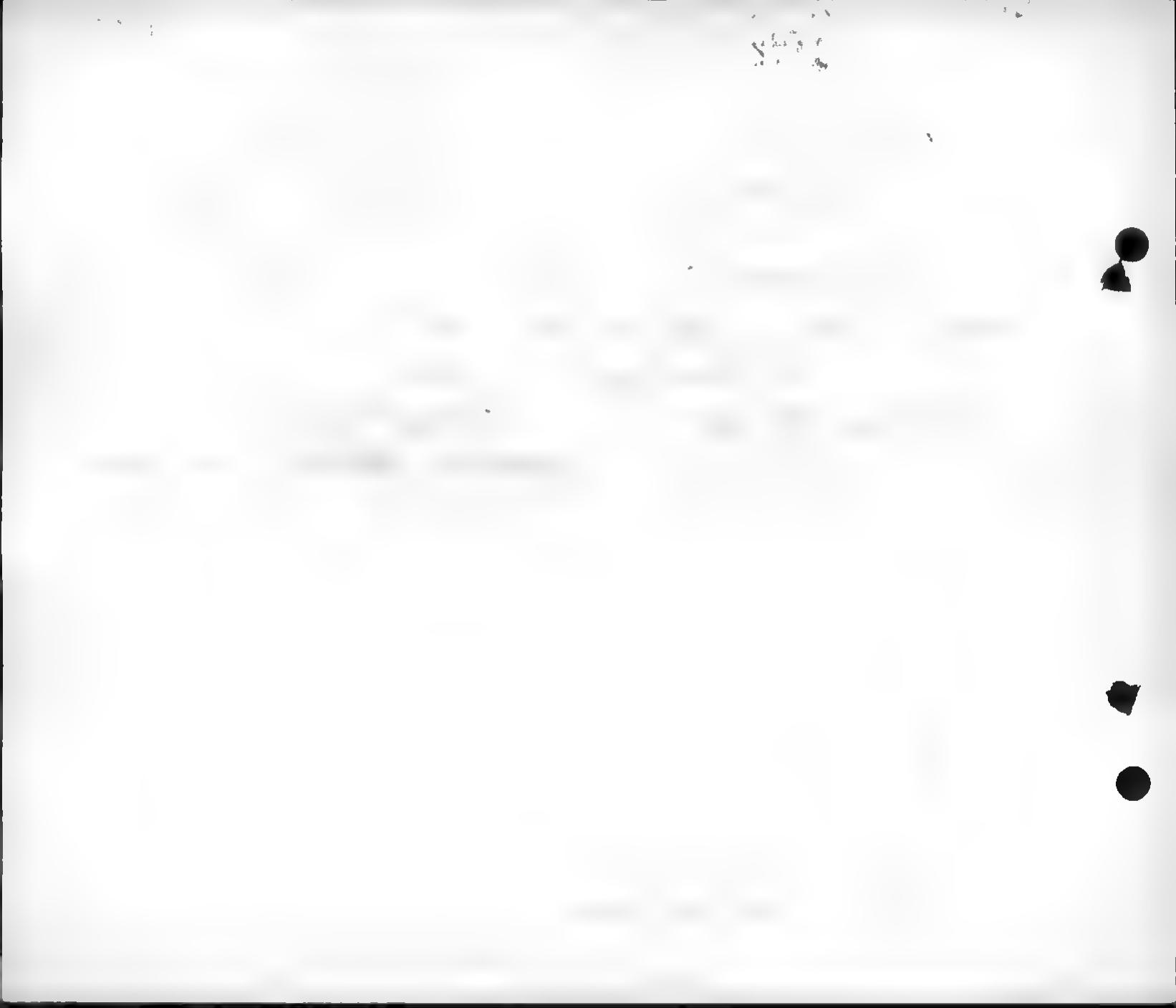
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REG. DATE REC'D BY LOCAL REG. DATE REC'D BY LOCAL REG.

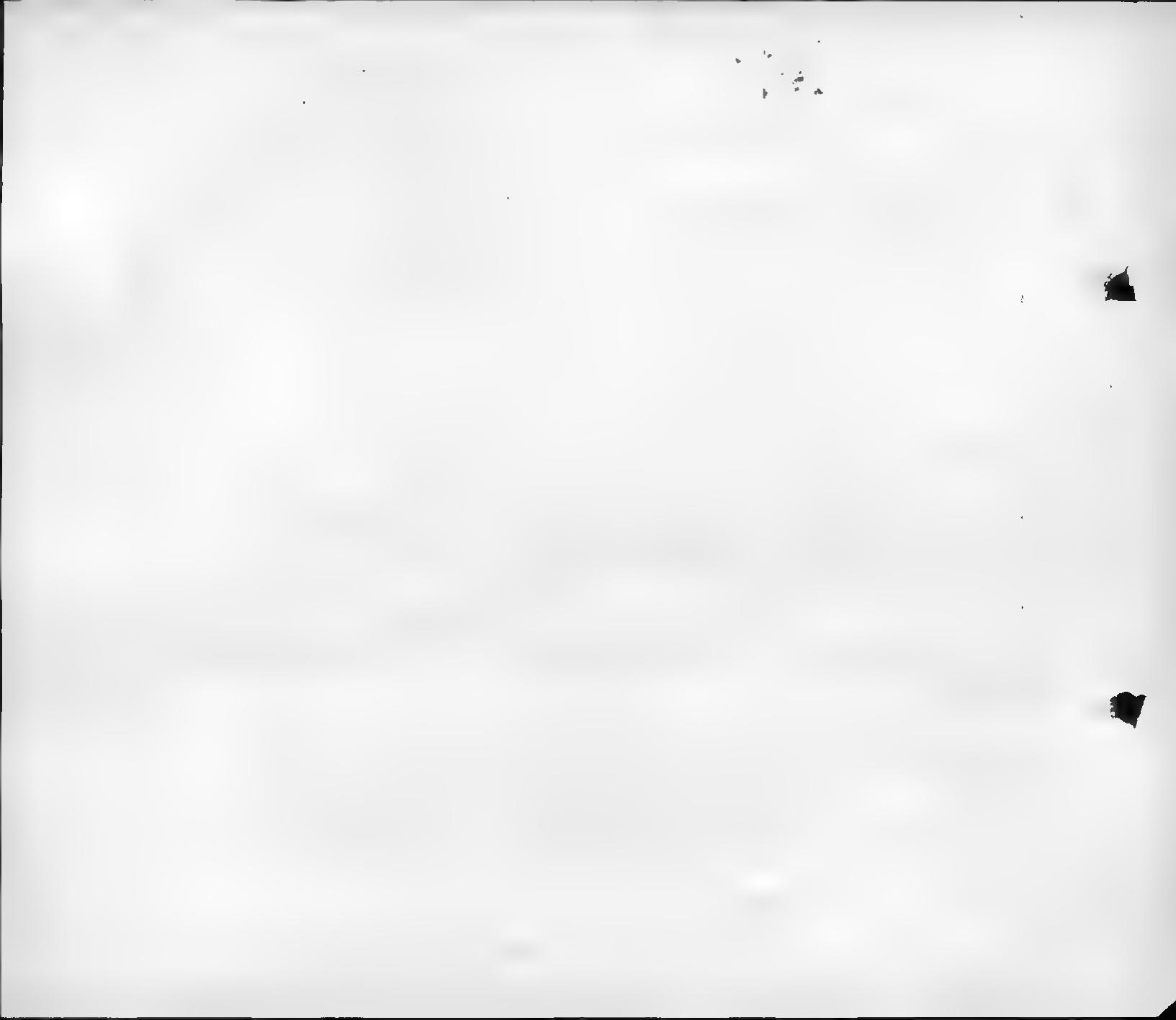
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01491  
**1521 CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <i>Balto.</i> CITY If outside corporate limits, write RURAL OR A 1/2 MILE NEAR TOWN TOWN <i>Gwynn Oak</i> LENGTH OF STAY (in this place) <i>17 yrs</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Md</i> COUNTY <i>Balto</i> CITY If outside corporate limits, write RURAL and give nearest town OR TOWN <i>Lutherville</i> <i>Balto Coo.</i> STREET ADDRESS <i>Lutherville</i> <i>Balto Coo.</i>	
3. NAME OF DECEASED. (Type or Print) <i>Georgeau</i>		4. DATE (Month) (Day) (Year) OF DEATH <i>2 19 1956</i>	
5. SEX: <i>M</i> COLOR OR <i>W</i> RACE: <i>Single, MARRIED, WIDOWED, DIVORCED.</i> (Specify) <i>Divorced</i>		6. DATE OF BIRTH <i>2/8/1860</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Records Augsburg Home</i>		9. AGE last birthday IF UNDER 1 YEAR Months <i>96</i> yrs Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	
10B. KIND OF BUSINESS OR INDUSTRY: <i>Chestnut Ridge</i>		11. FIFTH PLACE (State or foreign country) <i>Balto</i>	
13. FATHER'S NAME: <i>Geo Todd</i>		12. CITIZEN OF WHAT COUNTRY? <i>Canada</i>	
14. MOTHER'S MARRIED NAME: <i>Jane Mayer</i>		15. INFORMANT & ADDRESS <i>811 Locustwood Records Augsburg Home</i>	
16. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		17. INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE <i>Arterio-Sclerotic - Heart</i> <i>5 yrs.</i> ANTECEDENT CAUSE (S) <i>Diseases - c Atrial Fibrillation -</i> DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <i>Generalized Arterio-Sclerosis</i> <i>8 yrs.</i>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH		18. DATE OF OPERATION <i>196</i> MAJOR FINDINGS OF OPERATION 20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNINTENTIONAL <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE (Home, farm, fact., etc.) <i>21C. WHERE DID (City or town) OF INJURY street, office bldg., etc.) INJURY OCCUR? <i>(County) (State)</i></i>	
21D. TIME (Month Day) (Year) (Hour) OF INJURY <i>M. 1956</i>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <i>10/7</i> alive on <i>Feb. 16, 1956</i> , and that death occurred at SIGNATURE <i>Sam L. Chamber</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2/22/56</i> NAME OF CEMETERY OR CREMATORIAL <i>Carroll Hill</i> LOCATION (City, town, or county) <i>Balto Coo.</i> M.D. <i>4108 Liberty 1/2. C. B. B. 7-1/2</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Feb 21 1956</i>		REGISTRAR'S SIGNATURE <i>Goldie Hedrich</i> 24. FUNERAL DIRECTOR <i>Paul H. Hellmann</i> ADDRESS <i>6067 Harford Rd</i>	



## 1522 CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>Baltimore</b>	MARYLAND	STATE <b>Md.</b>	COUNTY <b>Baltimore</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	TOWN <b>Rural--White Hall</b>
TOWN <b>Rural--White Hall</b>	1 yr.	STREET ADDRESS	(If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)	(First) <b>JUDITH</b>	(Middle) <b>A.</b>	(Last) <b>PARDEW</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>Wh.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Wid.</b>	8. DATE OF BIRTH <b>Aug. 12, 1868</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home (Housewife)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (State or foreign country) <b>N.C.</b>
13. FATHER'S NAME <b>Elliott Welborn</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Snow</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT & ADDRESS <b>W.E. Pardew, White Hall, Md.</b>
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>CEREBRAL HEMORRHAGE</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Chr. Cardio-vascular Disease</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Lupus erythematosus</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
M.		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Jan. 31, 1956</b> , to <b>Feb. 13, 1956</b> , that I last saw the deceased alive on <b>2-12-56</b> , and that death occurred at <b>10 a.m.</b> from the causes and on the date stated above.		ADDRESS (Street, city, town, state) <b>Forest Hill, Md.</b>	
SIGNATURE <b>W. L. R. Hudson</b>		DATE SIGNED <b>2-14-56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Feb. 17, 1956</b>	
24. REC'D BY REGISTRAR <b>VS ABC 155 10M</b>		REGISTRAR'S SIGNATURE <b>Mrs. H. C. &amp; S. Markley</b>	
DATE <b>2-16-56</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. McComas &amp; Son, Abingdon, Md.</b>	
		ADDRESS <b>Forest Hill Cemetery</b>	



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A55 10A

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01493

1523

## CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Baltimore Monkton	MARYLAND LENGTH OF STAY (in this place)	STATE Md. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Monkton
HOSPITAL INSTITUTION OR STREET ADDRESS	Carroll Road	STREET ADDRESS (If rural give location)	Carroll Road
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
Estelle Hutchins Pearce		Feb 5 1956	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 5 December 1870
9. AGE last birthday 85 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country) Taylor Baltimore, Md.
13. FATHER'S NAME John Slade Hutchins	14. MOTHER'S MOTHER'S MAIDEN NAME Mary Jane Hawkins	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS Jacob H. Pearce Monkton, Md	18. MEDICAL CERTIFICATION	19. INTERVAL BETWEEN ONSET AND DEATH 2 yrs OVER 5 yrs	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		IMMEDIATE CAUSE (A) Cardiac Decompensation ANTECEDENT CAUSE(S) DUE TO (B) Arterio-sclerotic cardiovascular disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from....., 1950, to Feb 5, 1956, that I last saw the deceased alive on 3 Feb 1956, and that death occurred at 11 A.M. from the causes and on the date stated above. SIGNATURE <u>Walter Kees</u> ADDRESS (Street, city, town, state) <u>Cockeysville</u> DATE SIGNED <u>5 Feb. 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Feb 7-1956	NAME OF CEMETERY OR CREMATORIAL St. James	LOCATION (City, town, or county) Monkton, Md. (State)
24. REC'D BY REGISTRAR DATE 2-8-56	REGISTRAR'S SIGNATURE Mrs. Howard S. Martin	25. FUNERAL DIRECTOR'S SIGNATURE MARTIN, GENEVIEVE JARRELL	ADDRESS Jarrellsville

18. 1910

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained for us as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01494

## 1524 CERTIFICATE OF DEATH

Reg. Dist. No. 5C

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <b>Catonsville</b>		67 yrs.		TOWN <b>Catonsville</b>		TOWN <b>Catonsville</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>1937 Frederick Road</b>				STREET ADDRESS <b>1937 Frederick Road</b>			
3. NAME OF <b>WILLIAM R. H. PEEPLES</b> (First) (Middle) (Last)				4. DATE (Month) OF <b>Feb. 25,</b> 1956 (Day) (Year)			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 4, 1880</b>	9. AGE last birthday <b>75</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stationary Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>State Hospital</b>	11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		
13. FATHER'S NAME <b>Joseph Peeples</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-20-4148</b>			
17. INFORMANT & ADDRESS <b>Catonsville - 28, Md.</b>				18. MEDICAL CERTIFICATION <b>Mrs. Anna K. Peeples 1937 Fred. Rd.</b>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
<ul style="list-style-type: none"> <li>IMMEDIATE CAUSE (A) <b>Myocardial Infarction</b></li> <li>ANTECEDENT CAUSE(S) DUE TO (B) <b>Coronary Artery Disease</b></li> <li>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Ch. Hypertension Cardio-Vascular Disease</b></li> </ul>				<b>1da.</b>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<b>6 yrs</b>			
III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<b>12 yrs</b>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				21c. WHERE DID INJURY OCCUR? (City or town) (County) <b>M.D.</b> (State) <b>21c. WHERE DID INJURY OCCUR? (City or town)</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
21f. HOW DID INJURY OCCUR?				21g. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>3-6</b> , 19 <b>43</b> , to <b>2-25</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>2-24</b> , 19 <b>56</b> , and that death occurred at <b>3:30 A.M.</b> from the causes and on the date stated above.				ADDRESS (Street, city, town, state) <b>M.D. 6209 Frederick Ave. Baltimore, Md.</b> DATE SIGNED <b>2-27-56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>2/28/1956</b>		NAME OF CEMETERY OR CREMATORIAL <b>Good Shepherd Cem.</b>		LOCATION (City, town, or county) <b>Ellicott City, Md.</b> (State) <b>Ellicott City, Md.</b>	
24. REC'D BY REGISTRAR <b>DATE 2/27/56</b>		REGISTRAR'S SIGNATURE <b>T.E. Harry</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Eastern Crem. Catonsville, Md.</b>		ADDRESS	

Y. S.  
HAROLD  
H. G. E. V. E.

478 23 1052

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR FUNERAL DIRECTOR:** The law requires that the death certificate be executed within 24 hours after death. After this certificate has been executed by the attending physician or funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit. VS A15C-155 1044

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

01495

**CERTIFICATE OF DEATH**

Reg. Dist. No. 38

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town)	Baltimore Maryland	STATE CITY (If outside corporate limits, write RURAL and give nearest town)	COUNTY Maryland Baltimore
TOWN Loch Raven (Phoenix P.O.)	LENGTH OF STAY (In this place) Life.	TOWN Loch Raven (Phoenix P.O.)	(If rural give location) Dulaney Valley Road
HOSPITAL OR INSTITUTION OR STREET ADDRESS Dulaney Valley Road	STREET ADDRESS		
<b>3. NAME OF DECEASED (Type or Print)</b> WILLIAM EDWARD PEEERGE		<b>4. DATE OF DEATH</b> February 7, 1956	
SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH March , 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer-ret.		10b. KIND OF BUSINESS OR INDUSTRY Self employed	9. AGE last birthday 75 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward S. Pearce		14. MOTHER'S MAIDEN NAME Laura Pearce	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS Family Records		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  IMMEDIATE CAUSE (A) carcinoma of the lung ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, ■ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION X	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) home - no accident	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) no injury	
21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? X	
22. I hereby certify that I attended the deceased from 11/18/56, 19 , to 2/7/56, 19 , that I last saw the deceased alive on 1/7/56, 19 , and that death occurred at 9:33 P.M. from the causes and on the date stated above. SIGNATURE <i>Henry J. Keh</i> ADDRESS (Street, city, town, state) -1205 N. Calvert St. DATE SIGNED 2/9/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 10, 1956	NAME OF CEMETERY OR CREMATORIUM Trinity Episcopal Cemetery
24. REC'D BY REGISTRAR		LOCATION (City, town, or county) (State) Long Green, Baltimore, Md.	
DATE 10 1956		REGISTRAR'S SIGNATURE <i>Dr. A. M. Bacon</i> 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>John Burns, Son</i> , Towson, Maryland	



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 155 104

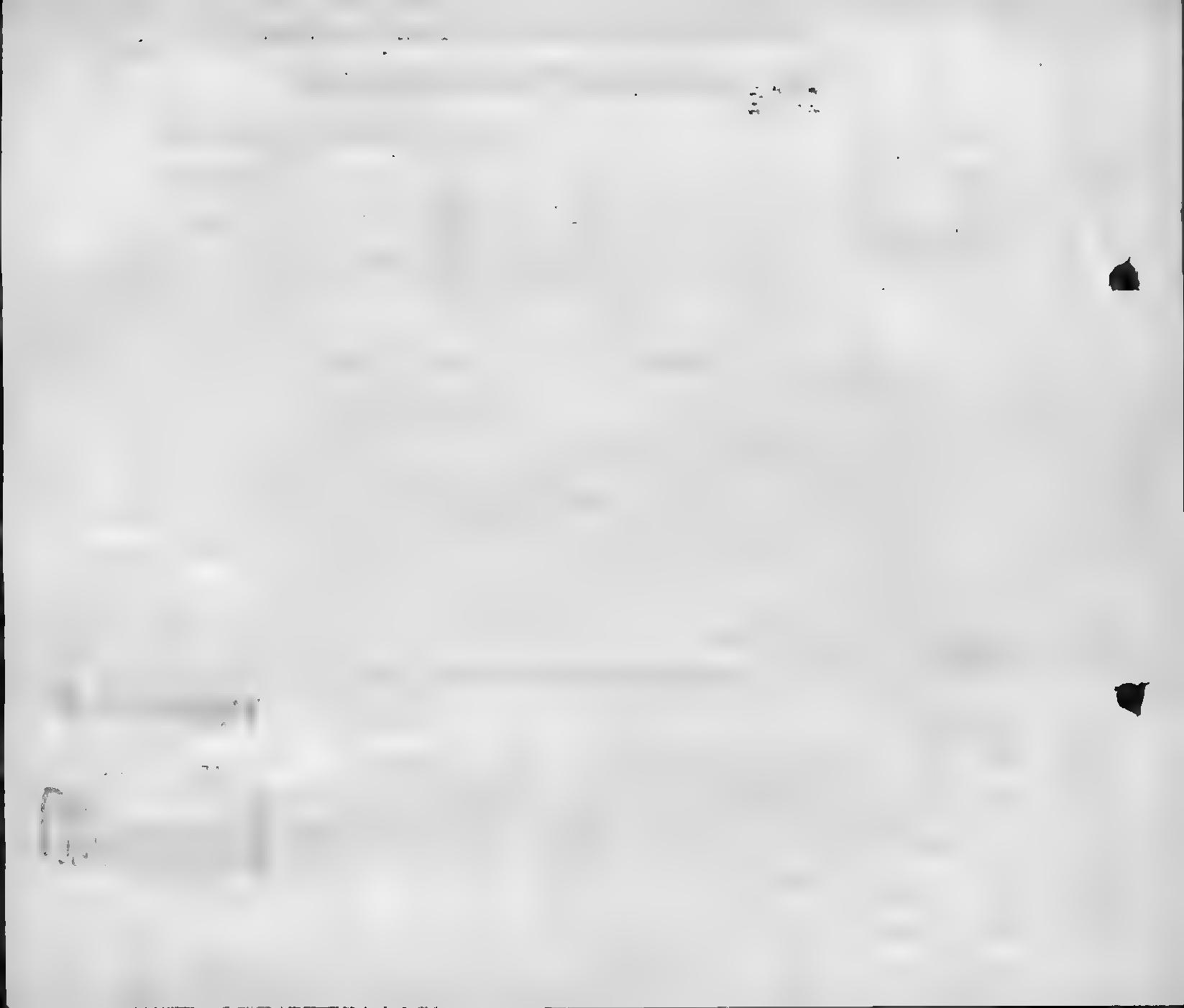
## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01496

## 1526 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	BALTO. CO.		MARYLAND LENGTH OF STAY (In this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Md PASADENA		COUNTY STREET ADDRESS (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	CATONSVILLE		8 DAYS	9 HARBOR Rd. BAYSIDE			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) MARGARET K. PEPPLER (Middle) (Last)				2/13/56 (Month) (Day) (Year)			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH 3/20/86	9. AGE last birthday 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				11. BIRTHPLACE (State or foreign country) Md			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Frederick Bauer				14. MOTHER'S MAIDEN NAME Anna Kahn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.			
(If Yes, give war or details of service)							
17. INFORMANT & ADDRESS Raymond J. Harris							
18. MEDICAL CERTIFICATION							
IMMEDIATE CAUSE (A) Cerebro Hemorrhage ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) (C) Hypertensive C.V.D INTERVAL BETWEEN ONSET AND DEATH 2 weeks							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3/27/48 to 2/13/56, that I last saw the deceased alive on 2/13/56, and that death occurred at 8:00 A.M. from the causes and on the date stated above. SIGNATURE J. D. Brown, M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2/16/56		NAME OF CEMETERY OR CREMATORIAL Gorraine		ADDRESS (Street, city, town, state) 3325 Frederick Ave DATE SIGNED 2/13/56 (State)	
24. REC'D BY REGISTRAR DATE 2-16-56		REGISTRAR'S SIGNATURE J.F. Harry		25. FUNERAL DIRECTOR'S SIGNATURE O'Malley & Son		ADDRESS	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01497

1527

## CERTIFICATE OF DEATH

Reg. Dist. No. 94

## 1. PLACE OF DEATH.

COUNTY BALTIMORE

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN FORT HOWARD

LENGTH OF STAY  
(in this place)

20 Hours

HOSPITAL OR  
INSTITUTION OR

STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL

3. NAME OF  
DECEASED:

(Type or Print) WILLIAM

SEX Male

RACE White

C.

PFEIFFER

6. COLOR OR  
RACE: 7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify): Single

## 8. DATE OF BIRTH:

December 10, 1877, 78

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life  
even if retired): Seaman10B. KIND OF BUSINESS  
OR INDUSTRY: Banana Boat

## 13. FATHER'S NAME:

Charles Pfeiffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) If Yes, give war or dates  
of service: Yes P. I.

## 16. SOCIAL SECURITY NO.

220-07-8762

## 17. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## IMMEDIATE CAUSE

(A) DIFFUSE MYOCARDIAL FIBROSIS WITH MURAL

## ANTECEDENT CAUSE (S)

THROMBI, LEFT VENTRICLE

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

DUE TO CORONARY ARTERIOSCLEROSIS

## (C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

LOBULAR PNEUMONIA

INTERVAL BETWEEN  
ONSET AND DEATH

UNKNOWN

UNKNOWN

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES  NO 21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory  
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

M.

While  Not while   
at work  at work 

11:30 AM

7:30 AM

22. I hereby certify that I attended the deceased from Feb. 15, 1956 to Feb. 16, 1956

and that death occurred at 7:30A M. from the causes and on the date stated above.  
ADDRESS DATE SIGNED

D. D. MARK, M.D.

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

Burial

DATE REC'D BY LOCAL  
REGISTRAR

Feb. 26, 1956

DATE THEREOF

REGISTRAR'S SIGNATURE

Hedrick

M. D. VAH, FORT HOWARD, MARYLAND

2-17-56

(State)

NAME OF CEMETERY OR CREMATORIAL LOCATION (C. I., town, or county)

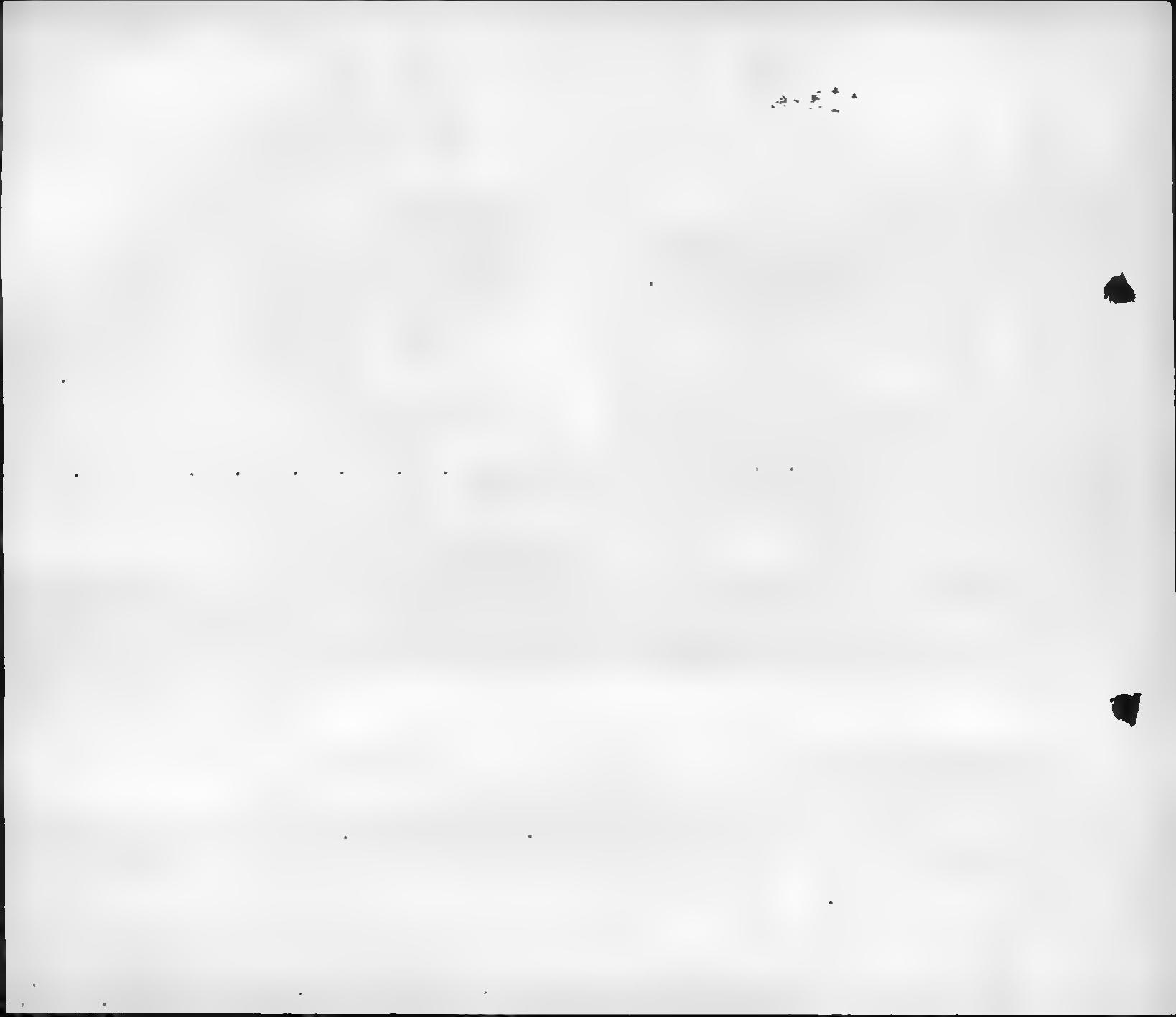
Parkwood Cemetery Baltimore, Maryland

ADDRESS

Wm. Cook-Blight, Inc.,

Md.

6009 Harford Rd., Balti-



## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1528

## 1. PLACE OF DEATH

COUNTY BALTIMORE

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN FORT HOWARD

LENGTH OF STAY  
(in this place)

59 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED.

STATE MARYLAND

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN BALTIMORE

STREET  
ADDRESS

(If rural give location)

2128 ORLEANS STREET

3. NAME OF  
DECEASED:  
(Type or Print)

(First) STANISLAW

(Middle)

(Last)

POLSKI

4. DATE (Month) (Day) (Year)

OF DEATH FEBRUARY 9

1956

5. SEX  
MALE6. COLOR OR  
RACE  
WHITE7. SINGLE MARRIED  
W. DOWER DIVORCED  
(Specify) MARRIED8. DATE OF BIRTH  
April 18, 18929. AGE last birthday  
6310. UNDER 1 YEAR  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired): Laborer10B. KIND OF BUSINESS  
OR INDUSTRY:  
Cemetery11. BIRTHPLACE (State or foreign country):  
Baltimore, Maryland12. CITIZEN OF WHAT  
COUNTRY?  
U. S. A.

## 13. FATHER'S NAME:

Valanty Polski

## 14. MOTHER'S MAIDEN NAME:

Mary Konikowska

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates  
of service) Yes WW I16. SOCIAL SECURITY NO.  
214-10-0191

## 17. INFORMANT &amp; ADDRESS:

Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.

18. MEDICAL CERTIFICATION  
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A)  
DUE TO

ADENOCARCINOMA, RECTUM

INTERVAL BETWEEN  
ONSET AND DEATH

1 YEAR

ANTECEDENT CAUSE (B)

(B)  
DUE TODISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION  
8/16/55 Transverse Colostomy20. AUTOPSY?  
YES  NO 21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
While  Not while   
at work  at work 

21F. HOW DID INJURY OCCUR?

M.

22. I hereby certify that I attended the deceased from Dec. 12, 1955, to Feb. 9, 1956, ~~and assisted in the care of the deceased~~~~and assisted in the care of the deceased~~, and that death occurred at 2:45 PM, from the causes and on the date stated above.  
SIGNATURE *Irving Freeman*

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, DATE THEREOF  
REMOVAL (SPECIFY)

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county) (State)

Burial

Feb 13, 1956 Holy Redeemer Cemetery

4430 Belair Road, Balto. Md.

DATE REC'D BY LOCAL  
REGISTRAR

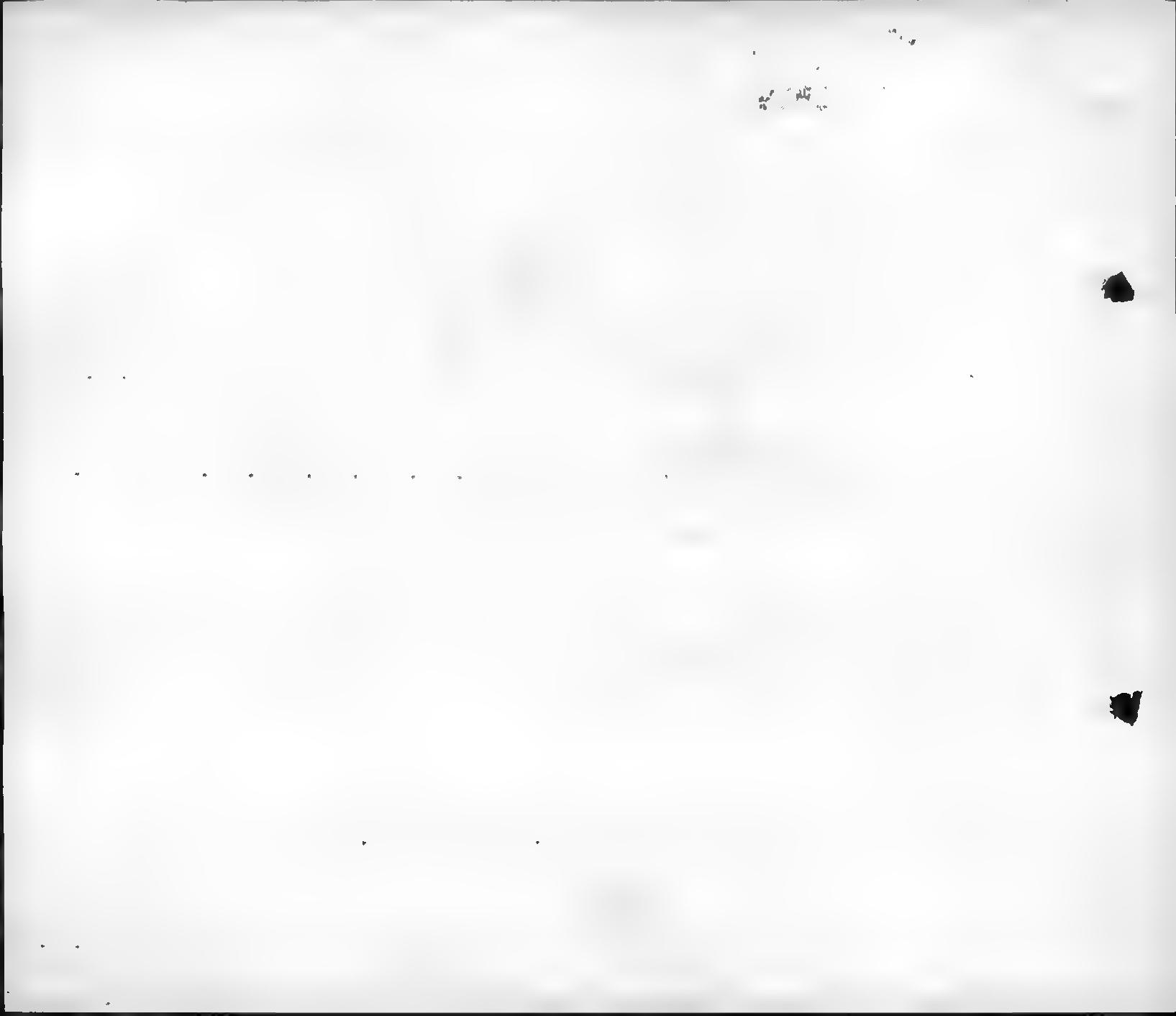
REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

February 11, 1956 R.W.

Lilly & Zeiler Inc., Fun. Dir. 1901 Eastern Av.  
Balto. Md.



## 1529 CERTIFICATE OF DEATH

Reg. Dist. No. 30

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-53 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	BALTO.	MARYLAND	STATE MD
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	COUNTY BALTO
TOWN CATONSVILLE	1 MO	TOWN 28 MELROSE AVE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)		
HOUSE IN PINES	CATONSVILLE		
3. NAME OF DECEASED (Type or Print)	(First) MABEL A. (Middle) PORTER (Last)		4. DATE (Month) (Day) (Year)
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH SINCE 3/10/1850
9. AGE last birthday 75 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	10b. KIND OF BUSINESS OR INDUSTRY office	11. BIRTHPLACE (State or foreign country) Neb.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Porter	14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS Hosp. records	18. MEDICAL CERTIFICATION
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		1000	
IMMEDIATE CAUSE (A) Bronchi-Pneumonia		3 MDT	
ANTECEDENT CAUSE(S) DUE TO (B) Myocardial Decompensation		20 PL(?)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Chronic Rheumatic Heart Disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 9-17, 1955, to 2-18, 1956, that I last saw the deceased alive on 2-18, 1956, and that death occurred at 7:45P.M. from the causes and on the date stated above.			
SIGNATURE		ADDRESS (Street, city, town, state) Catonville 28, MD DATE SIGNED 2-20-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 2/21/56	NAME OF CEMETERY OR CREMATORIUM London Park	LOCATION (City, town, or county) BALTO MD (State)
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE 2/21/56	John J. Gullager	John J. Gullager	28

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## MARYLAND STATE DEPARTMENT OF HEALTH

01501

1531 CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 47

1. PLACE OF DEATH: COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>MARYLAND</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <b>Oaklyn</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Rural-Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>6900 Belair Rd.</b>		STREET ADDRESS <b>6900 Belair Rd</b>	
3. NAME OF DECEASED (Type or Print) <b>Bertha Idella</b>		4. DATE OF DEATH <b>2 18 1956</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <b>Feb 7, 1886</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wm. Lee Tal</b>		14. MOTHER'S MIDDEN NAME <b>Eliza Jane Townsend</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W</b>	
17. INFORMANT AND ADDRESS <b>Grenade Punte - 4129 Martin Ave.</b>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>Immediate cause (a) <b>Coronary Occlusion</b></p> <p>Antecedent cause(s) (b) <b>Coronary artery disease</b></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>Cardiac failure - compensated</b></p>			
2. INTERVAL BETWEEN ONSET AND DEATH <b>5-10 min</b>			
3. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
4. INTERVAL BETWEEN ONSET AND DEATH <b>Several</b>			
5. INTERVAL BETWEEN ONSET AND DEATH <b>Several</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>	(CITY OR TOWN) <b>7527 Belair Rd</b>
TIME (Month) (Day) (Year) OF INJURY <b>Feb 19 1956</b>		INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/>	HOW DID INJURY OCCUR? <b>at work</b>
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined SIGNATURE <b>John C. Kyle, M.D.</b> (Degree or title) <b>ADDRESS</b> <b>7527 Belair Rd</b> DATE SIGNED <b>2-18-56</b>			
23. DATE OF DEATH REG. <b>Feb 19, 1956</b>		24. DATE THIEREOF REG. <b>Feb 21, 1956</b>	
25. NAME OF CEMETERY OR CREMATORIAL REG. <b>Burial</b>		26. LOCATION (City, town, or county) REG. <b>Mt. Olive M. E.</b>	
27. FUNERAL DIRECTOR REG. <b>John C. Kyle, M.D.</b>		28. ADDRESS REG. <b>John C. Kyle, M.D.</b>	
29. FIRM OR INDIVIDUAL REG. <b>John C. Kyle, M.D.</b>		30. ADDRESS REG. <b>John C. Kyle, M.D.</b>	
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317. FIRM OR INDIVIDUAL REG. <b>John C. Kyle, M.D.</b>		318. ADDRESS REG. <b>John C. Kyle, M.D.</b>	
319. FIRM OR INDIVIDUAL REG. <b>John C. Kyle, M.D.</b>		320. ADDRESS REG. <b>John C. Kyle, M.D.</b>	
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335. FIRM OR INDIVIDUAL REG. <b>John C. Kyle, M.D.</b>		336. ADDRESS REG. <b>John C. Kyle, M.D.</b>	
337. FIRM OR INDIVIDUAL REG. <b			

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**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

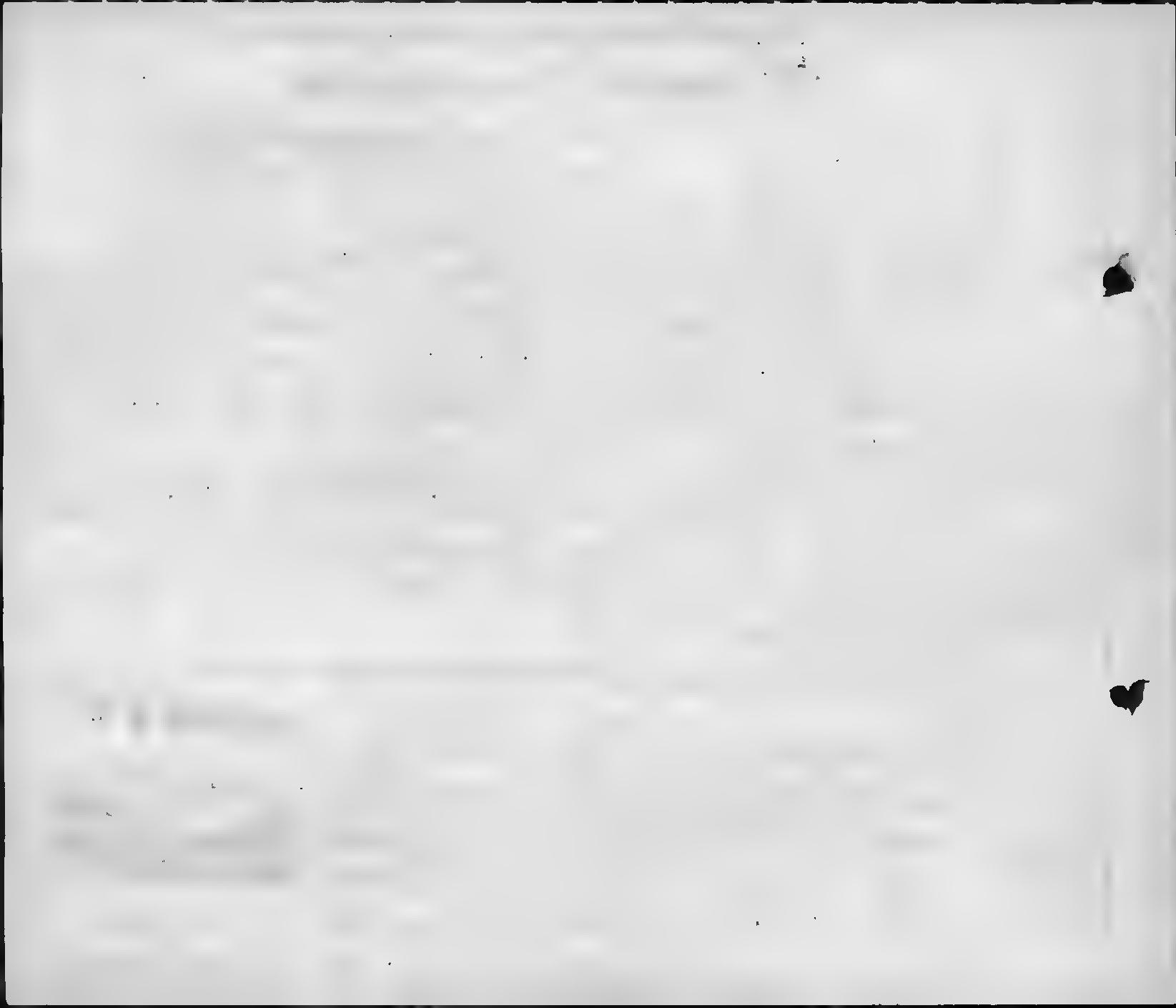
## 1532 CERTIFICATE OF DEATH

01502

Reg. Dist. No. ....

Item 12, Filr 3192 2-10-56 et

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	Baltimore	MARYLAND	STATE Maryland COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Length of Stay (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	STREET ADDRESS (If rural give location)
TOWN	Catonsville	TOWN	Parkville
HOSPITAL OR INSTITUTION OR STREET ADDRESS	5743 Edmondson Avenue		
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) Christian		(Month) (Day) (Year) Rau February 5th 19 56	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
male	white	widowed	Jan. 15, 1884
9. AGE last birthday	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
72 yrs.	Retired Tool Designer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
August Rau		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS	
18. MEDICAL CERTIFICATION		Mr. James Kotschenreuther, 8310 Harford	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A)		Hypertension Cardiovascular	
ANTECEDENT CAUSE(S) DUE TO (B)		renal disease	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		3 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		ANCINA PECTORIS.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Mar.</u> 1955, to <u>Feb. 5</u> 1956, that I last saw the deceased alive on <u>Feb. 5</u> 1956, and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.		ADDRESS [Street, city, town, state] DATE SIGNED	
SIGNATURE <u>J. Nelson McKay</u>		M. D. <u>6014 Edmondson Ave Feb. 5, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
Burial		NAME OF CEMETERY OR CREMATORIUM	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE	
DATE <u>Feb. 7, 1956</u>		ADDRESS	
		25. FUNERAL DIRECTOR'S SIGNATURE	
		Leonard J. Ruck, 5305 Harford Road #14	



## 1533 CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

COUNTY BALTO.

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN SPARROWS POINT (19)

MARYLAND

LENGTH OF STAY  
(in this place)

19 YRS

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

1027 H ST.

3. NAME OF  
DECEASED  
(Type or Print)

(First)

(Middle)

(Last)

## 4. SEX:

F.

6. COLOR OR  
RACE:

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify)

8. DATE OF BIRTH:

WIDOWED FEB. 13, 1872

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS  
OR INDUSTRY:

NONE

11. BIRTHPLACE (State or foreign country):

PENNA.

12. CITIZEN OF WHAT  
COUNTRY?

U. S. A.

13. FATHER'S NAME:

THOMAS MELVILLE

14. MOTHER'S MAIDEN NAME:

MARY McCARRAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES  
(Yes, no, or unk.) (If Yes, give war or dates  
of service)

NO

16. SOCIAL SECURITY NO.

NONE.

17. INFORMANT &amp; ADDRESS:

MRS. BERTHA SIMON - WEST CHESTER

PENNA.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

IMMEDIATE CAUSE

(A) DUE TO

Coronary Thrombosis

ANTECEDENT CAUSE (S)

(B) DUE TO

Hypertensive Atherosclerotic Lesions

(C) DUE TO

Senility.

20. AUTOPSY?

YES  NO INTERVAL BETWEEN  
ONSET AND DEATH

Immediate

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING

TO THE DEATH BUT NOT RELATED TO THE

DISEASE OR CONDITION CAUSING DEATH.

Bronchopneumonia.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County) (State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
While  Not while at work  at work 

21F. HOW DID INJURY OCCUR?

M. 

22. I hereby certify that I attended the deceased from July 15, 1956, to February 26, 1956, that I last saw the deceased

alive on February 24, 1956, and that death occurred at 5 P.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

M.D. Sparrows Point Md. 2/26/56

23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county)  
REMOVAL (SPECIFY)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

LAWSON L. LEE, WALTER WALTER BRADLEY, RANDALL, M.D.

FEB 29 1956

FEB 29 19

BUREAU V. S.

MAR 1 1956

REGISTRATION

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01504

1534

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: COUNTY Baltimore Co. MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore			
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Westmount		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS 5706 Edmonston Ave.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		(If rural, give location)			
3. NAME OF DECEASED (Type or Print)	(First) HILDA	(Middle) LOUISE	(Last) REGAN		
4. DATE OF DEATH	2-5-56	(Month)	(Day)	(Year)	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH	9. AGE last birthday	10. If under 1 year Months Days Hours Min.
Female	White		1899	56 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
At Home				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Kirchner		14. MOTHER'S MAIDEN NAME Mary Winter			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS Mr. F. L. Regan-5706 Edmonston Ave	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  Immediate cause (a) <i>Carcinoma of Brain</i>  Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____  19. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
20. AUTOPSY?		INTERVAL BETWEEN ONSET AND DEATH 7 months			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8/9, 1955, to 2/5, 1956, that I last saw the deceased alive on 1/26, 1956, and that death occurred at 7:30 a.m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED <i>Eliot W. Johnson M.D. 8432 Edmonston Baltimore 29 2nd</i>					
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 2-8-56		NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) Balto. City	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE <i>1956 Feb 11 Hedrich</i>		24. FUNERAL DIRECTOR ADDRESS Fred A. Cole 1515 W. Baltimore St.	

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be secured within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 4-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 1395 CERTIFICATE OF DEATH

0150547

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN)	Baltimore	MARYLAND	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Md.	COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Balto.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Arbutus	Life	STREET ADDRESS	Arbutus	(If rural give location)		
5514 Carville Ave				5514 Carville Ave			
3. NAME OF DECEASED (Type or Print)		(First) Tillie		(Middle) Rehling		4. DATE OF DEATH Feb. 26 1956	
5. SEX M.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH Apr. 19, 1876	9. AGE last birthday 79 yrs.	IF UNDER 1 YR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.		11. BIRTHPLACE (State or foreign country) Balto, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hucksell		14. MOTHER'S M AIDEN NAME Anna		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)			
				16. SOCIAL SECURITY NO. 220-07-3598			
17. INFORMANT & ADDRESS Mrs Myrtle Karweick, 5514 Carville Ave		18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
19a. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Hypertension a.s.c.v.d. IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DISEASE OR CONDITION CAUSING DEATH. Terminal Ulcer							
19b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19c. DATE OF OPERATION		19d. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White <input type="checkbox"/> at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2/12, 1953, to 2/26, 1956, that I last saw the deceased alive on 2/26, 1956, and that death occurred at 2:05 A.M. from the causes and on the date stated above. SIGNATURE John S. Tracy M.D. ADDRESS (Street, city, town, state) Baltimore, Md. DATE SIGNED 2/28/56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 29/56		NAME OF CEMETERY OR CREMATORIAL Western Cemetery		LOCATION (City, town, or county) Balto, Md. (State)	
24. REC'D BY REGISTRAR DATE Mar. 1, 1956		REGISTRAR'S SIGNATURE Dr. Geo. S. McLeifer Harry W. Witzke		25. FUNERAL DIRECTOR'S SIGNATURE 4101 Edmondson Ave		ADDRESS	

U. S. AIR FORCE

MAR 1 1955

100-2145

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01506

## 1535 CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR  
and give nearest town)LENGTH OF STAY  
(in this place)

TOWN Owings Mills, Maryland

8 $\frac{1}{2}$  yrs.HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Rosewood State Training School

3. NAME OF  
DECEASED:  
(Type or Print)

(First)

(Middle)

(Last)

Evelyn

Beatrice

Riggins

4. SEX:

female

6 COLOR OR  
RACE:

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.

(Specify):

single

8. DATE OF BIRTH:

9/30/37

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired):

never worked

10B. KIND OF BUSINESS  
OR INDUSTRY:

13. FATHER'S NAME:

Otis Brice Riggins

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates  
of service)

NO

16. SOCIAL SECURITY NO.

none

18. MEDICAL CERTIFICATION  
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A) Acute edema of brain with central respiratory  
DUE TO cessation

ANTECEDENT CAUSE (\$):

(B) Tumor 3rd Ventricle with hemorrhage  
DUE TODISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(C) Tuberous Sclerosis with symptomatic epilepsy

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE

DISEASE OR CONDITION CAUSING DEATH Tuberous sclerosis, Epilepsy, Hemiplegia, left

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO 

none

21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory  
OF INJURY street, office bldg., etc.)

none

21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
While  Not while   
at work  at work 

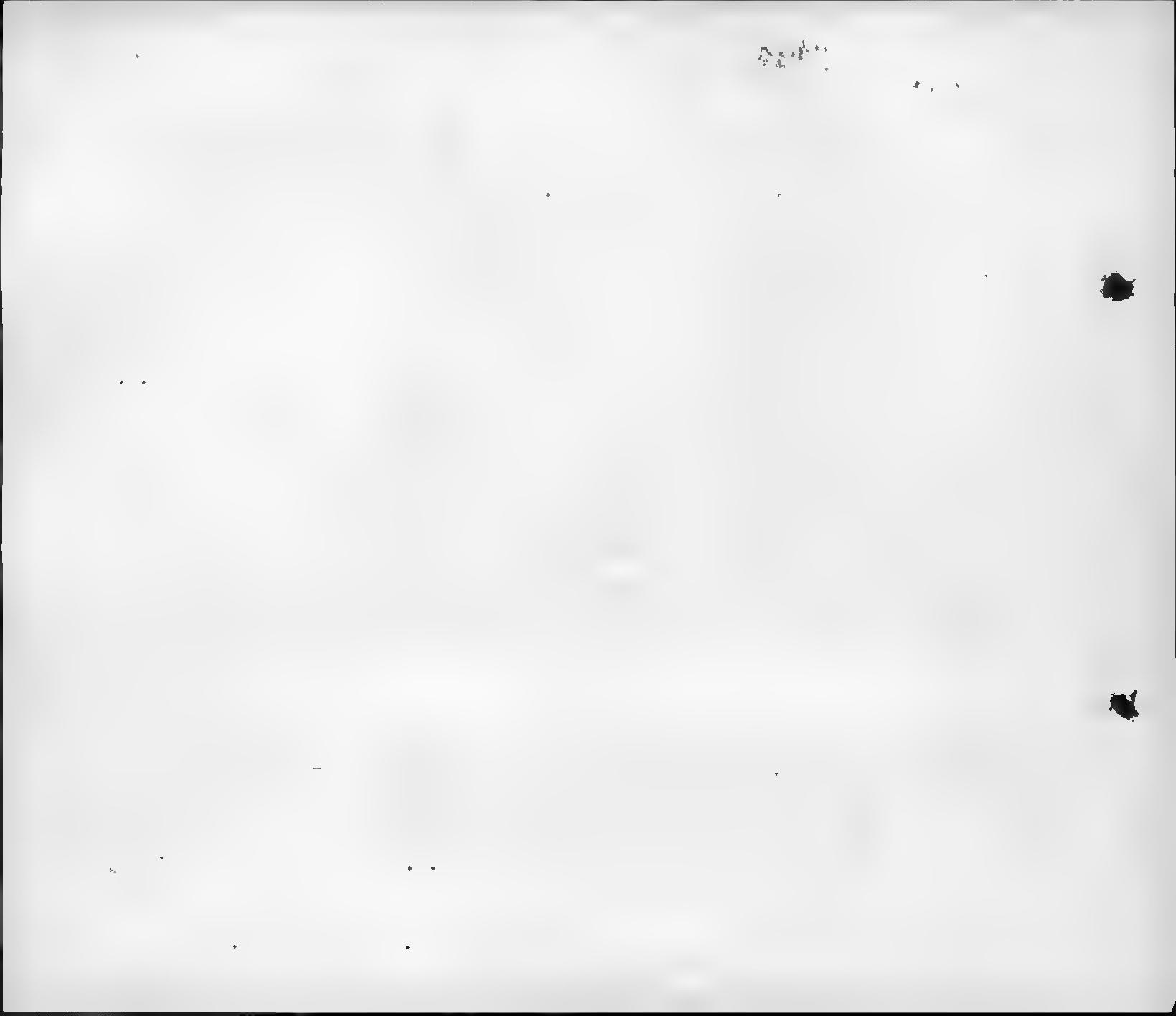
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/6/1956, to 2/7/1956, that I last saw the deceased

alive on 2/7/1956, and that death occurred at 12:10 M. M. from the causes and on the date stated above.  
SIGNATURE ADDRESS DATE SIGNEDHarry B. Butler MD  
BurialDATE THEREOF  
2/11/56NAME OF CEMETERY OR CREMATORIUM  
Fork Methodist Cem.LOCATION (City, town, or county)  
Fork, Md.

(State)

DATE REC'D BY LOCAL  
REGISTRAR  
Feb 12, 1956REG. STRR'S SIGNATURE  
Hedrick, M. J.FUNERAL DIRECTOR  
Lichner & SonsADDRESS  
17



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained for use as a burial transit permit.

V5 AISC 155 10A

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01508

## 1536 CERTIFICATE OF DEATH

Reg. Dist. No. 38

Item 6, Film 3192 2-17-56 et Item 7, Film 3192 2-20-56 et

## 1. PLACE OF DEATH

Balto.

COUNTY

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
TOWN Towson

MARYLAND

LENGTH OF STAY  
(In days/Place)  
2 yrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

Md.

COUNTY

Balto.

1 V. 104

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Stella Maris Hospice

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR  
TOWN

Baltimore, 18

STREET  
ADDRESS

4409 Greenway (If rural give location)

apt. Spring Rd./Baltimore Valley

3. NAME OF  
DECEASED  
(Type or Print)

(First) Cecilia

(Middle)

(Last)

Riley

4. DATE  
OF  
DEATH

2/8/56

(Month) (Day) (Year)

19

5. SEX

F

6. COLOR OR  
RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

S

8. DATE OF BIRTH

3/4/1874

9. AGE last birthday

81

yrs.

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)10b. KIND OF BUSINESS  
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT  
COUNTRY?

13. FATHER'S NAME

Patrick Riley

14. MOTHER'S MAIDEN NAME

Ann Byrnes

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT &amp; ADDRESS

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## 18. MEDICAL CERTIFICATION

INTERVAL BETWEEN  
ONSET AND DEATH

IMMEDIATE CAUSE

(A)

Pulmonary Edema

10 hrs.

ANTECEDENT CAUSE(S)

DUE TO

Hypertension of Cardiac -

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(B)

Renal Vasculitis Disease 10 yrs.

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO 21a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

M. White Not white  
at work at work22. I hereby certify that I attended the deceased from act, 1954, to February 1956, that I last saw the deceased  
alive on Feb 7, 1956, and that death occurred at 12 M, from the causes and on the date stated above.

SIGNATURE

Charles Donald M.D.

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

Burial

DATE THEREOF

2/11/1956

NAME OF CEMETERY OR CREMATORI

Cathedral Cemetery

LOCATION (City, town, or county)

Baltimore Md.

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

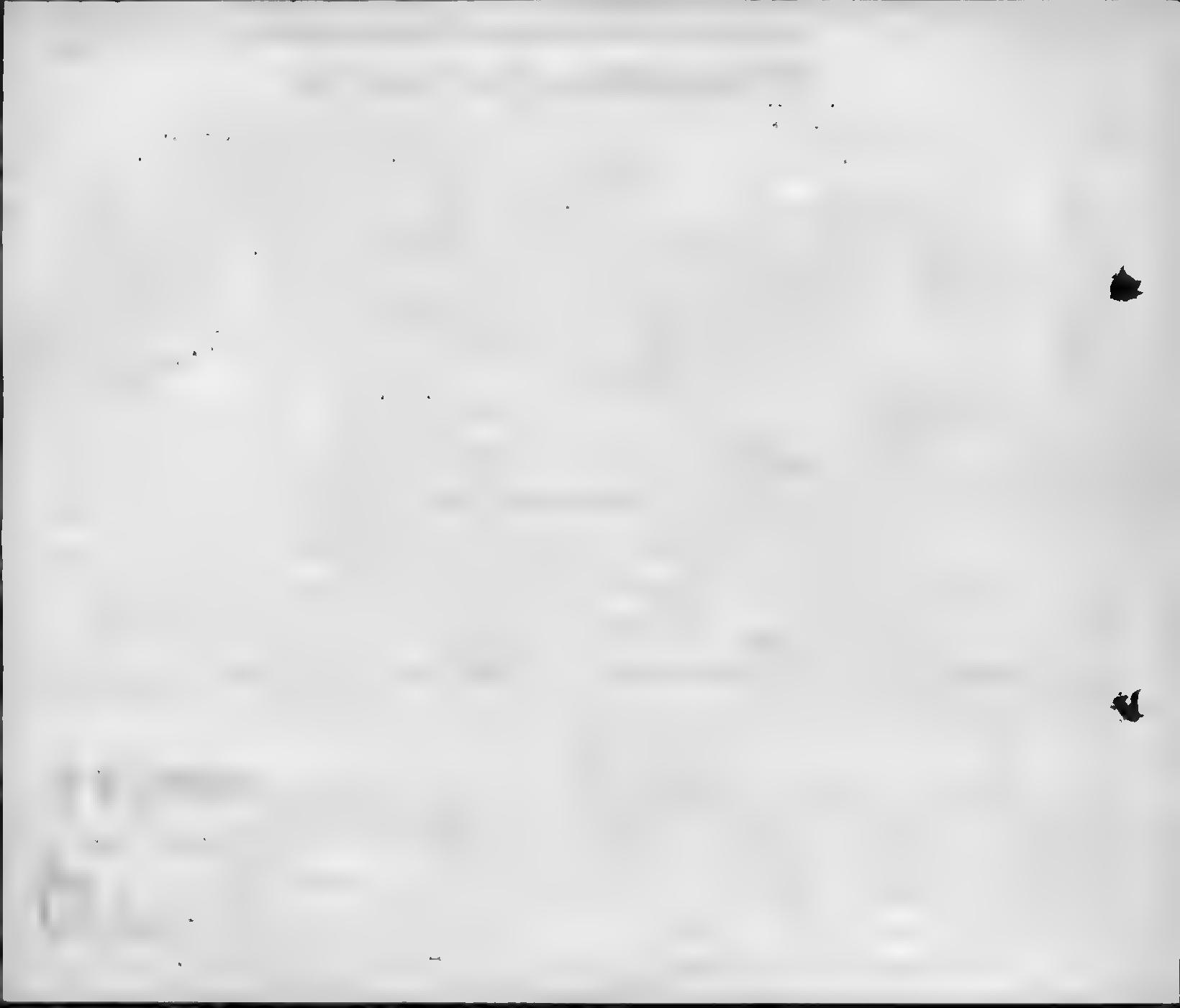
ADDRESS

DATE

Feb. 10, 1956

Mabel Gray

Flynn Flaming 1426 Light St.



**INSTRUCTIONS**

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 101

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

01509

**1537 CERTIFICATE OF DEATH**

Iter 1, Film G193 2-27-56 et

Reg. Dist. No. 30

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY	<b>BALTO.</b>	MARYLAND	STATE <b>MD</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)	COUNTY <b>BALTIMORE</b>
TOWN <b>CATONSVILLE</b>	<b>1 yr</b>		CITY (If outside corporate limits, write RURAL and give nearest town)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS <b>CATONSVILLE CONV. HOME</b>		
<b>3. NAME OF DECEASED</b> (First) <b>HARRY</b> (Middle) <b>THOMAS</b> (Last) <b>RILEY</b>		<b>4. DATE</b> (Month) <b>2/1</b> (Day) <b>1956</b> (Year)	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARR ED, W DWED, DIVORCED, (Specify)	8. DATE OF BIRTH <b>2/27/1890</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baltimore Water Dept</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <b>65</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>?</b>		12. CITIZEN OF WHAT COUNTRY? <b>?</b>	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS <b>Hosp. RECORDS</b>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A)		DUE TO <b>Acute pulmonary edema</b>	
ANTECEDENT CAUSE(S) DUE TO		B. GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <b>Left Venous Failure; ASCVD</b>	
INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs</b>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) <b>?</b> (State) <b>?</b>		21d. TIME OF INJURY (Month) <b>July</b> (Day) <b>2</b> (Year) <b>1955</b> (Hour) <b>10 A.M.</b>	
21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 2 1955</b> to <b>2-1 1956</b> that I last saw the deceased alive on <b>1-31 1956</b> , and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above.			
SIGNATURE <b>Stephens Wagner</b>		ADDRESS (Street, city, town, state) <b>908 Frederick C. Lerner Rd</b> DATE SIGNED <b>2-2-56</b>	
23. FUNERAL, CREMATION, RE-INTER (SPECIFY) <b>Burial</b>		DATE THRU/EOF <b>2/7/56</b>	NAME OF CEMETERY OR CREMATORIAL <b>Good Shepherd</b> LOCATION (City, town, or county) <b>Boward Co</b> (State) <b>?</b>
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <b>W.E. Harry MacNabb &amp; Son</b> ADDRESS <b>28</b>	
DATE <b>2-5-56</b>		25. FUNERAL DIRECTOR'S SIGNATURE	

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ESTATE TAXES

ESTATE

ESTATE TAXES

ESTATE TAXES

ESTATE TAXES

2/11/55

HARRY HOLLOWAY

2/11/55

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لأنه تغير في ملكية

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لأنه تغير في ملكية

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10/M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 1538 CERTIFICATE OF DEATH

01510

38

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	Baltimore	MARYLAND	STATE New York COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Ruxton	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Sorenson Nursing Home 7912 Ruxway	STREET ADDRESS	Brooklyn (If rural give location)
3. NAME OF DECEASED (First) (Middle) (Last)	4. DATE (Month) (Day) (Year)		
Mr. Leon S. Rivers	February 5th 1956		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
male	white	widowed	May 7, 1875
9. AGE last birthday	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
80 yrs.	Machinist		Brooklyn, New York
12. CITIZEN OF WHAT COUNTRY?	USA		
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Augustus H. Rivers	Elizabeth Stevenson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.		
(If Yes, give war or dates of service)	17. INFORMANT & ADDRESS		
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
<p>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>420.0 IMMEDIATE CAUSE (A) <i>arteriosclerosis, w/ t. disease</i></p> <p>ANTECEDENT CAUSE(S) DUE TO</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) <i>degenerative arteriosclerosis</i></p> <p>STATING UNDERLYING CAUSE LAST. DUE TO</p> <p>(C)</p>			
<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><i>years</i></p> <p><i>years</i></p>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		
21c. WHERE DID INJURY OCCUR? (City or town)	(County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21a. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?	
M.	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
22. I hereby certify that I attended the deceased from <i>Jan. 31, 1956</i> , to <i>Feb. 4, 1956</i> , that I last saw the deceased alive on <i>Feb. 4, 1956</i> , and that death occurred at <i>12:45 AM</i> , from the causes and on the date stated above.			
SIGNATURE	ADDRESS (Street, city, town, state)		
<i>Ernest C. Brown Jr.</i>	DATE SIGNED		
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL
Burial		Feb. 7, 1956	Baltimore National Cem.
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE	LOCATION (City, town, or county)
DATE		<i>Anne K. Ruck / ttr</i>	Baltimore, Maryland
Mrs. Mabel Graye		25. FUNERAL DIRECTOR'S SIGNATURE	
DATE		Leonard J. Ruck, 5305 Harford Road #11	

1000

900 4 8

100

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
9 FOR MEDICAL EXAMINERS

01511

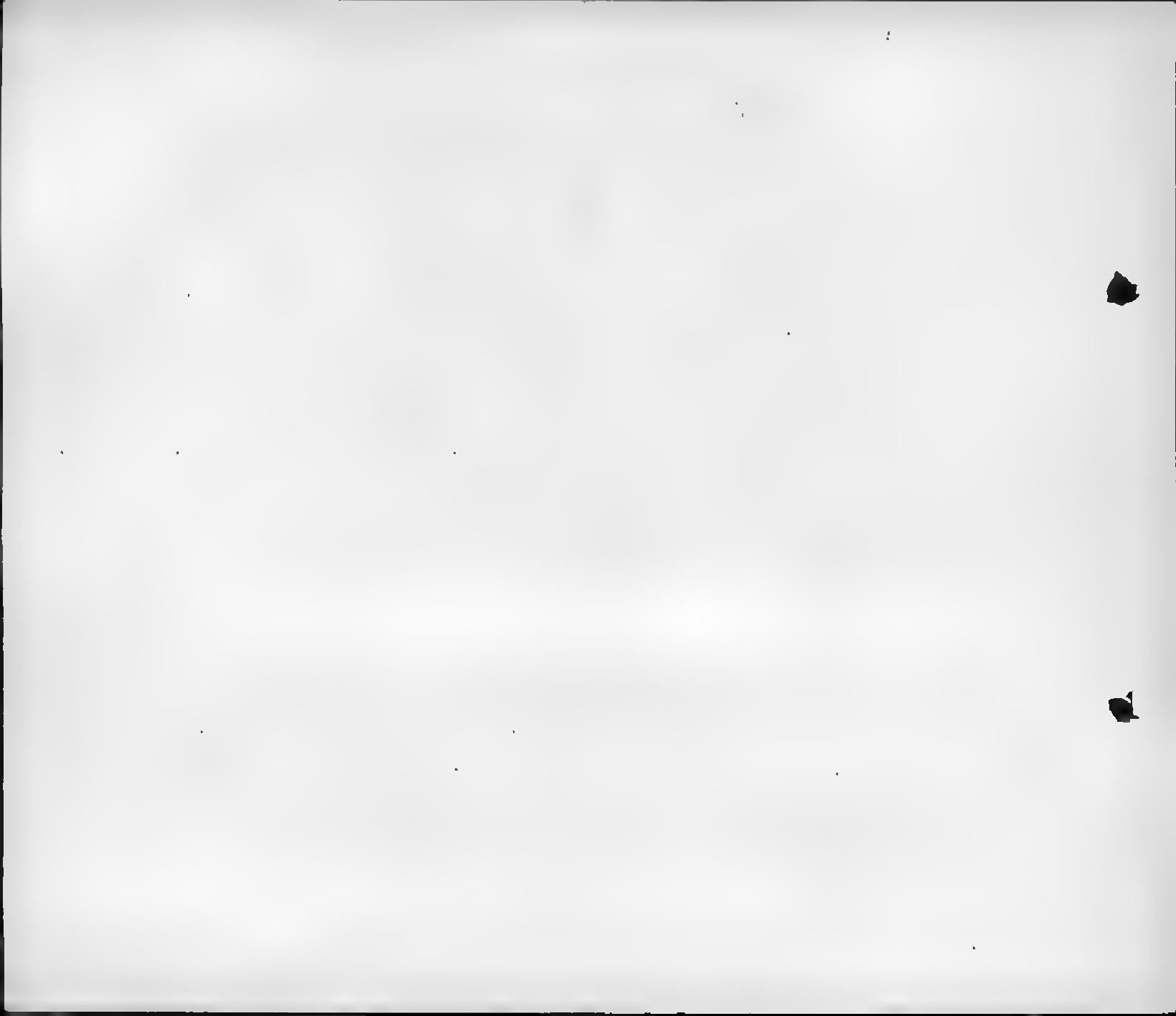
30

Reg. Dist. No.

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NARCISSUS RESERVE FOR BINDING

1. PLACE OF DEATH COUNTY Catonsville BAL MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore County	
CITY (If outside corporate limits, write RURAL and give nearest town) OR give nearest town) TOWN		LENGTH OF STAY (In this place) 2 mo	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springhouse State Farm		STREET ADDRESS 4301 Roland Ave	
3. NAME OF DECEASED (Type or Print) L. Corinne		(Last) R. o c h e	
4. SEX F.	5. COLOR OR RACE W.	6. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Singl	7. DATE OF BIRTH 11/26/1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home		10b. KIND OF BUSINESS OR INDUSTRY none	
13. FATHER'S NAME Charles		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ---		12. CITIZEN OF WHAT COUNTRY USA	
16. SOCIAL SECURITY No. none		17. INFORMANT Mrs. Ethel Beary, 12 Dixie Dr. Towson, Md.	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Cardiac Failure			
Antecedent cause(s) Diseases or conditions, if any, (b) giving rise to the above cause stating the underlying cause last (c) Generalized Arteriosclerosis			
Fracture of neck of right femur			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input checked="" type="checkbox"/> OF CAUSE OF DEATH. INJURY		PLACE (Home, farm, factory, street, of office bldg., etc.) (CITY OR TOWN) (COUNTY) hospit. Catonsville, Baltimore, Md.	
TIME (Month) (Day) (Year) (Hour) OF INJURY Febr. 6. 1956 m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? Pt. had a fall	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE George W. Heddle		ADDRESS 1010 N. Federal	
23. BURIAL, CREMATION REMOVAL (Specify) 2/24/56		DATE SIGNED 2/22/1956	
NAME OF CEMETERY OR CREMATORIAL RECEIPT		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REC'D Feb 23, 1956 G.W. Heddle		24. FUNERAL DIRECTOR Wm Cook, Inc., 1217 St. Paul Street	



## MARYLAND STATE DEPARTMENT OF HEALTH

01512

2411 N. Charles Street, Baltimore

## 1540 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS House in Pines Nursing Home		STREET ADDRESS 511 N. Street St.	
3. NAME OF DECEASED (Type or Print) (First) JULIUS CHRISTIAN ROHRBACH, Sr.		4. DATE OF DEATH Feb. 4, 1956	
5. SEX Male		6. COLOR OR RACE White	
7. SINGLE, MARRIED, WIDOWER, WIDOWED. (Specify) WIDOWER		8. DATE OF BIRTH July 19, 1880	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Post Office-Mail Clerk		10b. KIND OF BUSINESS OR INDUSTRY Retired 15 yrs	
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY SA	
13. FATHER'S NAME Wilhelm Rohrbach		14. MOTHER'S MAIDEN NAME Not Known	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Julius Rohrbach Jr.		18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary Thrombosis

INTERVAL BETWEEN  
ONSET AND DEATH  
1 hr.

Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last

(b) Chronic Hypertension Cardio-Vascular Disease

15 yr.

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)	(COUNTY)	(STATE)	
TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 2-2, 1952, to 2-4, 1956, that I last saw the deceased

alive on 2-5, 1956, and that death occurred at 7:45 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF Feb. 7, 1956	NAME OF CEMETERY OR CREMATORIALoudon Park Cemetery	LOCATION (City, town, or county) Baltimore Md.	(State)
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE A. W. Hendrich		24. FUNERAL DIRECTOR HENRY SANDER & SONS, INC.	
Feb. 6, 1956		J. C. Hendrich		ADDRESS Baltimore Md.	
				Henry J. Sander	



## 1541 CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH: COUNTY Baltimore CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Essex		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Essex	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 817 Silver Avenue		STREET ADDRESS 817 Silver Avenue	
3. NAME OF DECEASED: (Type or Print) EDWARD A.		4. DATE (Month) (Day) (Year) OF DEATH: Feb. 27, 1956	
5. SEX male		6. COLOR OR RACE: white	
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): single		8. DATE OF BIRTH: June 8, 1876	
10A. USUAL OCCUPATION Give kind of work done during most of working life. even if retired): Laborer		10B. KIND OF BUSINESS OR INDUSTRY: Roberts Can Co.	
13. FATHER'S NAME: Edward A. Rollison		14. MOTHER'S MAIDEN NAME: Isatella Simpson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-03-1117	
17. INFORMANT & ADDRESS: Mabel Vogel, 817 Silver venue,		18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST	
		(A) DUE TO <i>Generalized Arterosclerosis</i> (B) DUE TO <i></i> (C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH <i>Years</i>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21B. PLACE (Home, farm, factory OR INJURY street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from 3/1/56 to 2/27/56, that I last saw the deceased alive on 2/25/56, and that death occurred at 6A M. from the causes and on the date stated above. SIGNATURE <i>Robert J. Lyden</i>		21F. HOW DID INJURY OCCUR? ADDRESS <i>M.D. 815 Eastern Ave.</i> DATE SIGNED <i>2/27/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		DATE THEREOF 3/1/56 NAME OF CEMETERY OR CREMATORIAL Mt. Carmel Cemetery LOCATION (C. I. town, or county) Paltimore, Maryland (State)	
DATE REC'D BY LOCAL REGISTRAR <i>1/29/56</i>		REGISTRAR'S SIGNATURE <i>Robert J. Lyden</i> 24. FUNERAL DIRECTOR ADDRESS <i>Wm. Cork Inc. 1217 St. Paul St.</i>	



## 1396 CERTIFICATE OF DEATH

Reg. Dist. No. .

## 1. PLACE OF DEATH

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL  
 OR and give nearest town)  
 TOWN Arbutus LENGTH OF STAY  
 (in this place)

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS

5510 Willys Ave.

3. NAME OF  
 DECEASED:  
 (Type or Print)

(First)

(Middle)

(Last)

6. COLOR OR  
 RACE: white 7. SINGLE, MARRIED,  
 WIDOWED, DIVORCED.  
 (Specify): married 8. DATE OF BIRTH:  
Sept. 9, 1897 9. AGE last birthday  
58 yrs. 10. KIND OF BUSINESS  
 OR INDUSTRY: at home

10A. USUAL OCCUPATION (Give kind of  
 work done during most of working life,  
 even if retired): Housewife

10B. KIND OF BUSINESS  
 OR INDUSTRY:

## 13. FATHER'S NAME:

Eli Gaslow

15. WAR DECEASED EVER IN U.S. ARMED FORCES  
 (Yes, no, or unk.) (If Yes, give war or dates  
 of service) NO

16. SOCIAL SECURITY NO.

18. MEDICAL CERTIFICATION  
 I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## IMMEDIATE CAUSE

(A)  
 DUE TO

Interinsularis CVD

## ANTECEDENT CAUSE (B)

(B)  
 DUE TO

Diabetes Mellitus

DISEASES OR CONDITIONS, IF ANY,  
 GIVING RISE TO THE ABOVE CAUSE  
 STATING UNDERLYING CAUSE LAST

(C)

INTERVAL BETWEEN  
 ONSET AND DEATHII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH

Wheezing

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
 YES  NO 

21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
 (If either, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory,  
 OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town)  
 INJURY OCCUR?

(County) (State)

21D. TIME (Month) (Day) (Year) (Hour)  
 OF INJURY

21E. INJURY OCCURRED  
 While  Not while   
 at work  at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/2, 1953, to 2/12, 1956, that I last saw the deceased  
 alive on 2/12, 1956, and that death occurred at 4:02 PM, from the causes and on the date stated above.  
 SIGNATURE John E. B. B. ADDRESS 412 E. 23rd St., Baltimore, Md. DATE SIGNED 2/12/56

23. BURIAL, CREMATION,  
 REMOVAL (SPECIFY)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county) (State)

Burial

2/15/56

Glen Haven Cem.

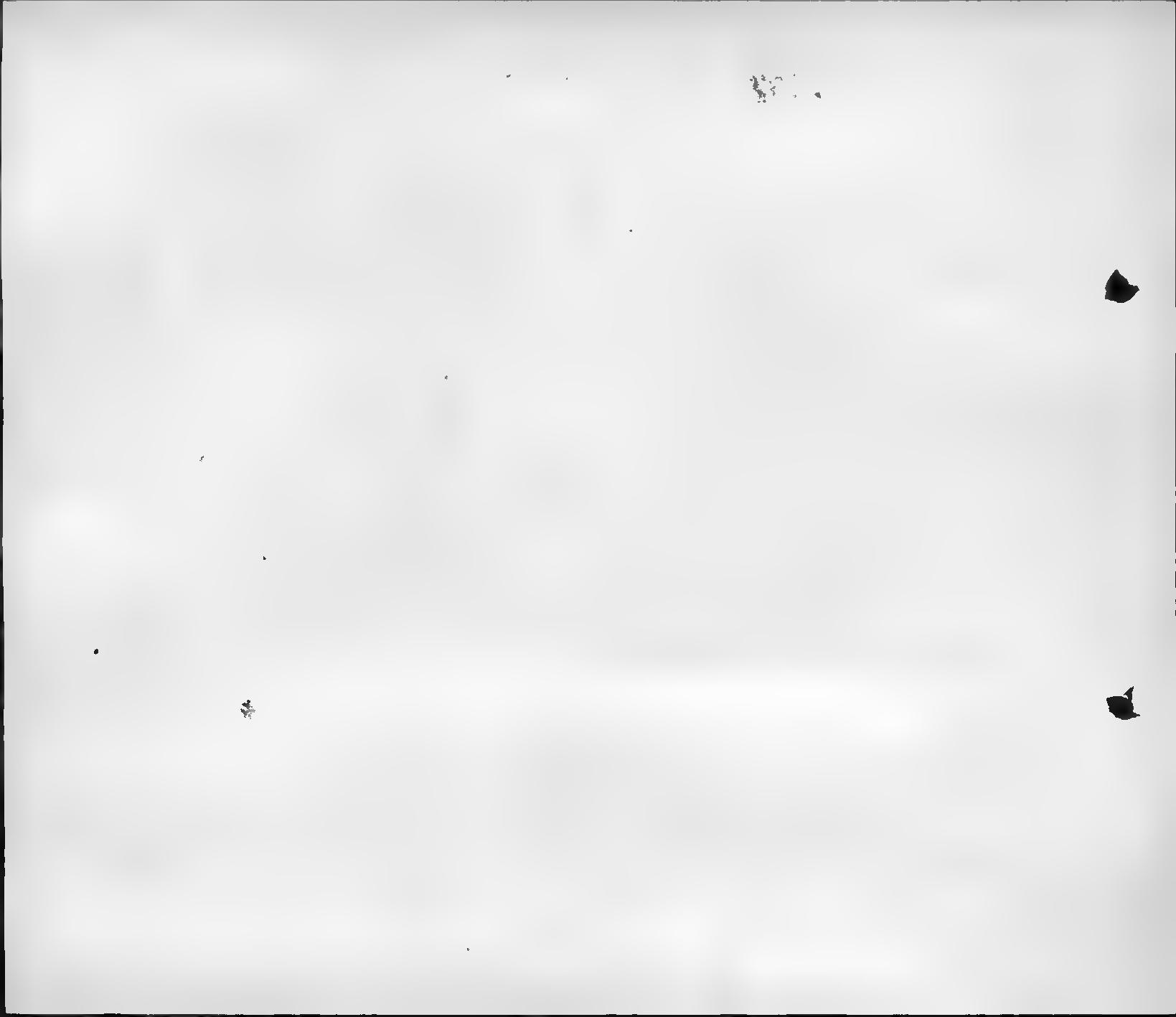
Glen Burnie, Md.

DATE REC'D BY LOCAL  
 REGISTRAR 1/15/56

REGISTRAR'S SIGNATURE John E. B. B.

FUNERAL DIRECTOR John E. B. B.

ADDRESS 412 E. 23rd St., Baltimore, Md.



## MARYLAND STATE DEPARTMENT OF HEALTH

01515.

2411 N. Charles Street, Baltimore

1387

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Dundalk, Maryland		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dundalk, Maryland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3488 Dunhaven Road		STREET ADDRESS 3488 Dunhaven Road	
3. NAME OF DECEASED (Type or Print) Bronislawa		4. DATE OF DEATH 2 3 1956	
(First) (Middle) (Last)		5. SEX Female	
6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Ignatz (I. N. Unknown)		14. MOTHER'S MAIDEN NAME Catherine Wolkiewiec	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --	
17. INFORMANT AND ADDRESS Frank Luzakowski Dundalk, 22- Md.		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 6 days 26 yrs	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
4 Immediate cause (a) Hereditary thrombosis			
Antecedent cause(s) (b) Diabetes - gen.			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes 20 yrs			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 14, 1955, to 2-2, 1956, that I last saw the deceased alive on 2, 1956, and that death occurred at 6 AM m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED Dell Colleen, M.D. 2111 Charles St. Bldt 22 2-4-56			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 2/7/56 NAME OF CEMETERY OR CREMATORIALy Holy Rosary LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REG. FEB 5 - 1956		REG. 24. FUNERAL DIRECTOR ADDRESS	
REG. FEB 5 - 1956		Mr. Williams, Jr. Practitioner of Law, 1001 A, Lansdowne St., Baltimore, Md.	

5. A. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01516

## 1542 CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

COUNTY BALTIMORE

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN FORT HOWARD

MARYLAND

LENGTH OF STAY  
(in this place)

9 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND

COUNTY BALTIMORE

3016 SPARROWS POINT ROAD

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN BALTIMORE (14)

(If rural give location)

STREET ADDRESS

3016 SPARROWS POINT ROAD

3. NAME OF  
DECEASED:

(First)

(Middle)

(Last)

RICHARD

FILLMORE

SANDERS

(Type or Print)

MALE

WHITE

6. COLOR OR  
RACE:7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.

(Specify)

MARRIED

8. DATE OF BIRTH:

3-24-93

9. AGE last birthday, IF UNDER 1 YEAR, IF UNDER 24 HRS.

yrs. Months Days Hours Min.

62

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired)10B. KIND OF BUSINESS  
OR INDUSTRY:

ERECTOR

STEEL COMPANY

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT  
COUNTRY?

Richmond, Virginia

U.S.A.

13. FATHER'S NAME:

Mell Sanders

14. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk) (If Yes, give war or dates  
of service) Yes WW-1

SOCIAL SECURITY NO.

216-10-4144  
Unknown

15. INFORMANT &amp; ADDRESS:

Clin. Rec., Vet. Adm. Hosp., Fort Howard, Md.

## 16. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

IMMEDIATE CAUSE

(A) BRONCHOGENIC CARCINOMA RIGHT LUNG

UNKNOWN

ANTECEDENT CAUSE (S)

B. DUE TO  
COPPER WITH METASTASIS TO BRAINDISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO 21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,  
street, office bldg., etc.)21C. WHERE DID INJURY OCCUR?  
(City or town)

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
While  Not while   
at work  at work 

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 3, 1956, to Feb. 12, 1956, that I certify the deceased  
died at 3:15 AM, from the causes and on the date stated above.  
SIGNATURE *D. Clark, M.D.* ADDRESS *3016 Sparrows Point Road, Baltimore, Md.* DATE SIGNED *2-12-56*23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)  
BURIALDATE THEREOF  
2-15-56

NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL  
REGISTRAR  
20 1956REGISTRAR'S SIGNATURE  
*Dawson L. Farber*GENERAL DIRECTOR ADDRESS  
Walter Brooks Bradley Funeral Home  
700 Willow Spring Rd., Baltimore 22, Md.

2000

131

17



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118

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-510A

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01518

## 1543 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY	Baltimore	MARYLAND	STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL or and give nearest town)	Towson	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	606 Anneslie Road	STREET ADDRESS	606 Anneslie Road (If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		
Mrs. Josephine A. Sauerwein		February 13 1956		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	
female	white	married	Aug. 21, 1896	
9. AGE last birthday	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
59 yrs.	at home		Baltimore, Maryland	USA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
Mr. James Bacon		Lydia Gallagher		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS
(If Yes, give war or dates of service)		=		Mr. George P. Sauerwein, 606 Anneslie Rd.
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
<p>IMMEDIATE CAUSE (A)</p> <p>ANTECEDENT CAUSE(S) DUE TO (B)</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATEMENT UNDERLYING CAUSE LAST. DUE TO (C)</p>				Myocardial infarction
				Epinephrine C.V. Dis
				Hepatoma + Diabetes mellitus
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		(County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?
		M. at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		
22. I hereby certify that I attended the deceased from <u>August, 1954</u> , to <u>February, 1956</u> , that I last saw the deceased alive on <u>July 13, 1956</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.				
SIGNATURE <u>Chase Gray Jr.</u> M.D. ADDRESS (Street, city, town, state) <u>6201 York Rd</u> DATE SIGNED <u>2/13/56</u>				
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county) (State)
Burial		2/16/1956	New Cathedral Cemetery	Baltimore, Maryland
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	
		<u>Mabel Gray</u>	Leonard J. Ruck, 5305 Harford Road #14	
DATE <u>11/5/1956</u>			ADDRESS	

LAUREAU V. S.

FEB 16

REGENT

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1801519

## 1397 CERTIFICATE OF DEATH

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

COUNTY BALTIMORE

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN ARBUTUS

LENGTH OF STAY  
(in this place)

12 YRS.

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

1826 BIRCH AVE

3. NAME OF  
DECEASED:  
(Type or Print)

FLORENCE V. SCHAEFER

3. SEX:

FEMALE

6. COLOR OR  
RACE:

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify):

WIDOWED

8. DATE OF BIRTH:

Nov. 6, 1867

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired)

HOUSEWORK

10B. KIND OF BUSINESS  
OR INDUSTRY:

Own Home

## 13. FATHER'S NAME:

William H. Orem.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates  
of service)

NO

16. SOCIAL SECURITY NO.

None

18. MEDICAL CERTIFICATION  
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A)  
DUE TO

Coronary occlusion

INTERVAL BETWEEN  
ONSET AND DEATH  
1 hr

ANTECEDENT CAUSE (S)

(B)  
DUE TO

Arteriosclerosis Generalized

5 yrs

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(C)

Tendinitis

Hypertensive cardiovascular disease 10 yrs

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION.

## 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES  NO 21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, notify MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,  
street, office bldg., etc.)

OF INJURY

21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
While  Not while   
at work  at work 

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1954, to Feb 22, 1956, that I last saw the deceased

alive on Dec 7, 1955, and that death occurred at 11A M, from the causes and on the date stated above.  
ADDRESS DATE SIGNED 2-23-56SIGNATURE  
G. Bradley Daugherty M.D.23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county) (State)

2/25/56

LORRAINE PAPA

BALTIMORE, MARYLAND

BURIAL

DATE REC'D. BY LOCAL

REGISTRAR

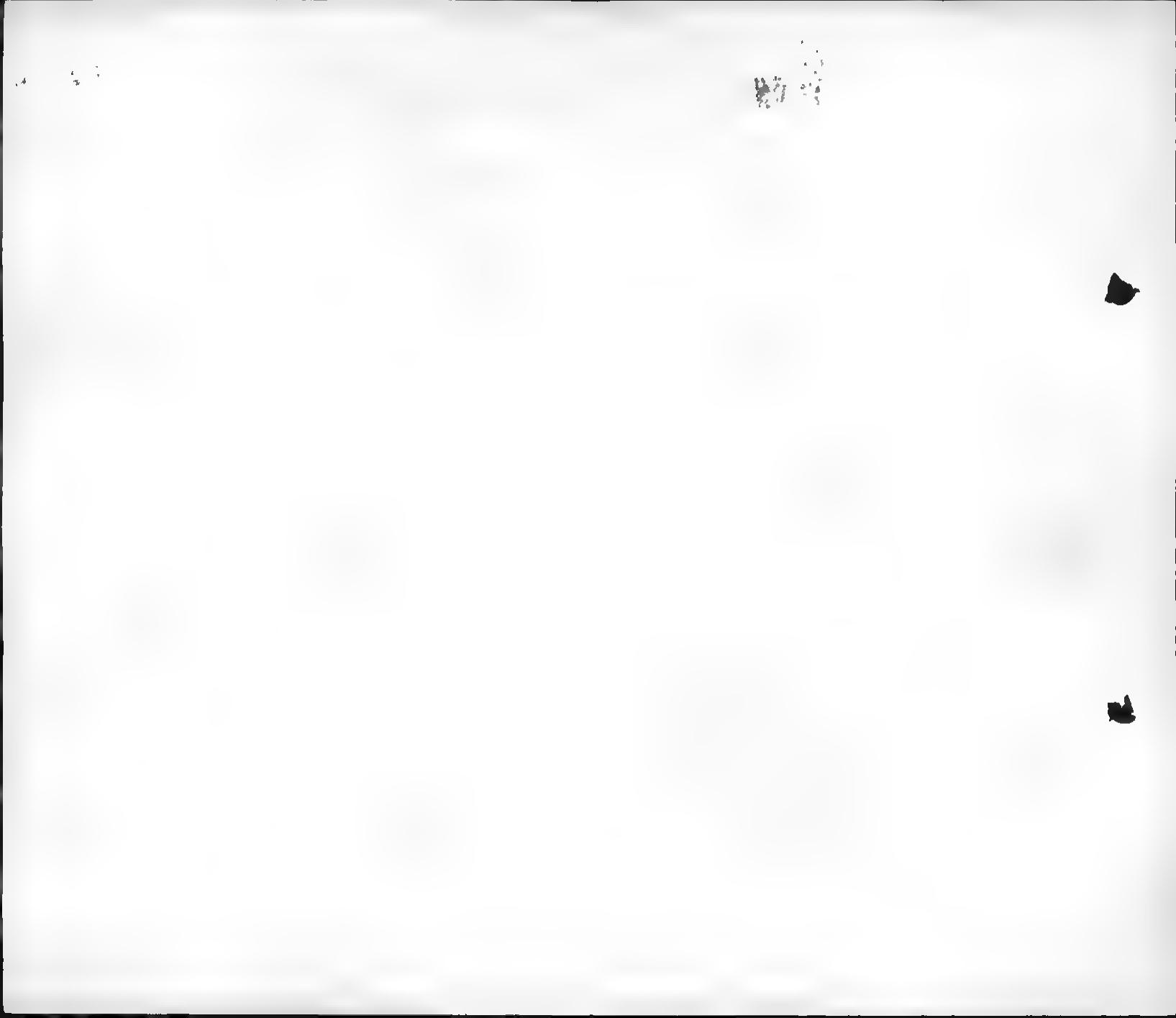
REGISTRAR'S SIGNATURE

V

24. FUNERAL DIRECTOR

ADDRESS

Joseph J. Muller, 1328 Larchmont St. Bldg. B21.



01520

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN)	Baltimore Maryland Woodlawn	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Md. Baltimore Woodlawn
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH: Feb. 5 1956	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married	8. DATE OF BIRTH: Apr. 20, 1880
10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE last birthday IF UNDER 1 YEAR Months Days Hours Min.	
Babinet maker		10B KIND OF BUSINESS OR INDUSTRY: Wm. Harbaugh	
13. FATHER'S NAME: John Schmidt		11. BIRTHPLACE (State or foreign country): Baltimore, Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give WBT or dates of service) No		12. CITIZEN OF WHAT COUNTRY?	
16. MEDICAL CERTIFICATION		17. INFORMANT & ADDRESS: Marie Schmidt - 5602 Windsor Mill Rd.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE		10 weeks	
ANTECEDENT CAUSE (S)		3 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A DATE OF OPERATION.		19B MAJOR FINDINGS OF OPERATION	
21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21C WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21E. INJURY OCCURRED While at work		21F HOW DID INJURY OCCUR? Not white at work	
22. I hereby certify that I attended the deceased from June 1944, to 2-5-1956, that I last saw the deceased alive on 2-2-1956, and that death occurred at 9:30 PM, from the causes and on the date stated above. SIGNATURE: <i>John Schmidt</i> ADDRESS: <i>5907 Oregon Park</i> DATE SIGNED: <i>2-7-56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2/8/56	
DATE REC'D. BY LOCAL REGISTRAR: <i>2-8-1956</i>		NAME OF CEMETERY OR CREMATORIAL Lorraine Cemetery	
REGISTRAR'S SIGNATURE: <i>John Schmidt</i>		LOCATION (City, town, or county) (State) Baltimore, Md.	
24 FUNERAL DIRECTOR'S ADDRESS: <i>Ellsworth Armacost - 4600 Liberty Heights Ave.</i>		REGISTRAR'S SIGNATURE: <i>John Schmidt</i>	



1545

## **CERTIFICATE OF DEATH**

Reg. Dist. No. 30

30

WRITING PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

<b>1. PLACE OF DEATH:</b> COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Catonsville</u> LENGTH OF STAY (in this place) 30 yrs				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> STATE <u>Md</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u> STREET ADDRESS If rural, give location <u>612 Plymouth Road</u>			
<b>3. NAME OF DECEASED:</b> (First) <u>KARL</u> (Middle) <u>SCHMIED</u> (Last)		<b>4. DATE OF DEATH:</b> (Month) <u>Feb</u> (Day) <u>9</u> (Year) <u>1956</u>					
<b>5. SEX:</b> <u>Male</u> <b>6. COLOR OR RACE:</b> <u>White</u>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)</b> <u>Widowed</u>		<b>8. DATE OF BIRTH:</b> <u>Oct. 16. 1861</u>		<b>9. AGE last birthday:</b> <u>94</u> IF UND <sup>ER</sup> 1 YEAR yrs. <u>94</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life) <u>Supervisor</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY:</b> <u>German Orphan Home Switzerland</u>		<b>11. BIRTHPLACE</b> (State or foreign country): <u>Switzerland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME:</b> <u>Unknown</u>		<b>14. MOTHER'S MAIDEN NAME:</b> <u>Unknown</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of)		<b>16. SOCIAL SECURITY NO.:</b> <u>none</u>		<b>17. INFORMANT &amp; ADDRESS:</b> <u>Otto P. Schmied 1317 Hindernore Ave.</u>			
<b>18. MEDICAL CERTIFICATION</b>							
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b> <p><u>Arteriosclerotic Heart Disease</u> (a) <u>Generalized Arteriosclerosis</u> (b) <u>Unknown</u> (c)</p> <p>Immediate cause (a) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>Generalized Arteriosclerosis</u></p> <p>Antecedent cause(s) (b) <u>Generalized Arteriosclerosis</u> DUE TO <u>Unknown</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Unknown</u></p>							
<b>II. OTHER SIGNIFICANT CONDITIONS:</b> Conditions contributing to the death but not related to the disease or condition causing death.							
<b>19a. DATE OF OPERATION:</b>				<b>19b. MAJOR FINDINGS OF OPERATION:</b>			
<b>20. AUTOPSY?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
<b>21. ACCIDENT SUICIDE HOMICIDE</b> (Specify)		<b>PLACE</b> (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		<b>(CITY OR TOWN)</b> <u>Baltimore</u>		<b>(COUNTY)</b> <u>Md</u> <b>(STATE)</b>	
TIME (Month) <u>Feb</u> (Day) <u>11</u> (Year) <u>1956</u> (Hour) <u>M.</u> OF INJURY		<b>INJURY OCCURRED</b> While at <input type="checkbox"/> Not while <input type="checkbox"/> work <input type="checkbox"/> at work <input type="checkbox"/>		<b>HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from....., 1949, to....., 1956, that I last saw the deceased alive on....., 1956, and that death occurred at....., 1956, m., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>J. Schmied</u> <b>(DEGREE OR TITLE)</b> <u>1 Mallow Hill Ave.,</u> <b>DATE SIGNED</b> <u>Baltimore 29, Md 2/10/56</u>							
<b>23. BURIAL, CREMATION REMOVAL (Specify):</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Feb 11-1956</u>		<b>NAME OF CEMETERY OR CREMATORIUM</b> <u>Oak Lawn</u>		<b>LOCATION</b> (City, town, or county) <u>Baltimore</u> <b>(State)</b> <u>Md</u>	
<b>DATE REC'D BY LOCAL REG.</b> <u>2/10/56</u>		<b>REGISTRAR'S SIGNATURE</b> <u>John E. Harry</u>		<b>24. FUNERAL DIRECTOR</b> <u>John H. Gengel</u>		<b>ADDRESS</b> <u>5311 Edmondson Ave.</u>	

125

125

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be submitted within 24 hours after death. After this bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10A

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01522

## 1546 CERTIFICATE OF DEATH

Items 8,9: film G193 3-5-56L

Reg. Dist. No. 30

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED										
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN TOWN	Baltimore Catonsville	MARYLAND LENGTH OF STAY (In this place)	STATE MD. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN TOWN									
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)										
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH										
(First) Rust		(Month) Feb. 14 (Day) 19 56										
(Middle)	(Last) Scott	5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	1893	9. AGE last birthday	62 97 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Ticket Mgr.	11. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY?
					April 24, 1911					Waiter-Vernay	Vermont	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME										
Lucius B. Scott		Jeanie Furrill										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS								
(If Yes, give war or dates of service)				Mrs. Eliza Scott 6314 Fred. Ave.								
18. MEDICAL CERTIFICATION										INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH										2 mo.		
IMMEDIATE CAUSE		(A)		Myocardial Decompensation								
ANTECEDENT CAUSE(S)		DUE TO		Chronic Atrial Fibrillation								
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE		(B)										
STATING UNDERLYING CAUSE LAST.		DUE TO										
		(C)										
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.										6 yr.		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County)		(State)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?								
22. I hereby certify that I attended the deceased from 11 A.M. to 1 P.M., 1956, that I last saw the deceased alive on 2-13, 1956, and that death occurred at 5 P.M. from the causes and on the date stated above.												
SIGNATURE Walter K. Gallo												
23. BURIAL, CREMATION, REMOVAL (SPECIFY) removal		DATE THEREOF 2-14-56		NAME OF CEMETERY OR CREMATORIAL cemetery		ADDRESS (Street, city, town, state) M.D. 6209 Frederick Rd. Baltimore 28 Md. 2/14/56		DATE SIGNED 2/14/56				
24. REC'D BY REGISTRAR DATE Feb. 16, 1956		REGISTRAR'S SIGNATURE V.E. Harry		25. FUNERAL DIRECTOR'S SIGNATURE Foley Funeral Home Catonsville, Md.		LOCATION (City, town, or county) Richmond Vir. Minis		ADDRESS				

REED V. S.

Feb 16 19

REED V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01523

Items 8 &amp; 9: Film G194

3/14/56 dmr.

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH.

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Fort Howard

LENGTH OF STAY  
(In this place)

47 Days

2. HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Veterans Administration Hospital

3. NAME OF  
DECEASED  
(Type or Print)

WILLIAM

(First)

A

(Middle)

SCOTT

JR.

(Last)

## 4. SEX.

6 COLOR OR  
RACE:

Male

White

7 SINGLE  
WIDOWED, DIVORCED

(Specify):

Married

8. DATE OF BIRTH.

12/16/97

97

9 AGE last birthday

58

119

yrs.

10 IF UNDER 1 YEAR

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired):

Plumber

10B. KIND OF BUSINESS  
OR INDUSTRY:

Plumber

11. BIRTHPLACE (State or foreign country):

Baltimore, Maryland

12. CITIZEN OF WHAT  
COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

William A. Scott, Sr.

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown)

(If Yes, give war or dates  
of service)

Yes

WW-I

16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS:

Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## IMMEDIATE CAUSE

## ANTECEDENT CAUSE (S)

## DISEASES OR CONDITIONS, IF ANY,

## GIVING RISE TO THE ABOVE CAUSE

## STATING UNDERLYING CAUSE LAST

## (A)

DIRECTOR

WITH METASTASIS TO KIDNEYS

## (B)

DUE TO

## (C)



01524

## MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital		STREET ADDRESS Helping Up (If rural, give location) Lombard & Green Sts.	
3. NAME OF DECEASED (Type or Print)	(First) Fred	(Middle)	(Last) Seiling
4. SEX Male	5. COLOR OR RACE White	6. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) DIVORCED	7. DATE OF BIRTH 2-11-1880
8. DATE OF DEATH February 3, 1956	9. AGE last birthday 75 yrs.	10. under 1 year Months	11. under 24 hrs. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY
13. FATHER'S NAME John Seiling	14. MOTHER'S MAIDEN NAME Catherine Whipple	15. MEDICAL CERTIFICATION	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT AND ADDRESS Records Spring Grove State Hospital	18. INTERVAL BETWEEN ONSET AND DEATH 5 days
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause Lobar pneumonia	(a)		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)		
(c)			
16. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of stomach			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE Geo. W. Kieffer	Deep me	ADDRESS 1010 Leeds ave	DATE SIGNED 2/3/56
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF Feb 6-1956	NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) London Park Baltimore	(State) Md
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE J. W. Frederick	24. FUNERAL DIRECTOR Wm. Cook Jr. - 1217 St. Paul St.	ADDRESS J. E.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNPADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1549

## CERTIFICATE OF DEATH

Item 7, FilmG193 2-27-56 et

Reg. Dist. No. 413

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL or and give nearest town)  
 LENGTH OF STAY  
 (in this place)  
 TOWN Raspeburg 104 yrs  
 HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS 7418 Brightside Ave

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY Baltimore  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN Raspeburg  
 STREET ADDRESS  
 (If rural give location)  
7418 Brightside Ave

3. NAME OF  
DECEASED:  
(First)  
(Type or Print)

5. SEX:

6. COLOR OR  
RACE:

IDA

Celestial

shenk

Female White

10a. USUAL OCCUPATION Give kind of  
work done during most of working life,  
even if retired): athome7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify): Widowed

8. DATE OF BIRTH:

Aug 7-1871

84

4. DATE  
OF  
DEATH: Feb

18

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REGISTRATION  
NUMBER 48

FEB 23 1936

**INSTRUCTIONS**

1

**TO ATTENDING PHYSICIAN OR HOSPITAL** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician it should be completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53.10A

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

01526

**1550 CERTIFICATE OF DEATH**

Reg. Dist. No. 9837

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY	Baltimore	MARYLAND	STATE Maryland COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN Lutherville			TOWN Lutherville
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Bellona Avenue		STREET ADDRESS (If rural give location)
Bellona Avenue		Bellona Avenue	
<b>3. NAME OF DECEASED</b> (First) JOHN BARCLAY (Middle) SHOCK (Last)		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) Feb. 24, 1956	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH May 26, 1894
9. AGE last birthday 61 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk	11. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME George Shock	14. MOTHER'S MAIDEN NAME Rebecca Parks	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) Yes ✓ WW I	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Family Records	
<b>18. MEDICAL CERTIFICATION</b> I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <i>Coronary heart disease,</i> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 74 days.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>6/28/1955</i> to <i>2/24/1956</i> , that I last saw the deceased alive on <i>1/1/28</i> , 1955, and that death occurred at <i>10 P.M.</i> from the causes and on the date stated above. SIGNATURE <i>Bennett A. Mackay M.D. Coroner for the City of Baltimore</i> ADDRESS <i>[Redacted]</i> <i>2/27/56.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Feb. 28, 1956	NAME OF CEMETERY OR CREMATORIAL Prospect Hill Cemetery	LOCATION (City, town, or county) (State) Towson, Maryland
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <i>Anne A. Mackay</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>John Burman</i> ADDRESS <i>Towson, Maryland</i>	
DATE <i>5</i>			

LIBRARY

LIBRARY

LIBRARY

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-155 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

1551

**CERTIFICATE OF DEATH**

01527

Reg. Dist. No. 30

Lynn L. FilmG193 2-28-56 et

**1. PLACE OF DEATH**

COUNTY **Baltimore**  
 CITY (If outside corporate limits, write RURAL  
 OR  
 TOWN **Baltimore**)

**MARYLAND**

LENGTH OF STAY  
 (In this place)

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE **Md.**  
 COUNTY **Baltimore**  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN **Baltimore 25**

**3. NAME OF  
 DECEASED**  
 (Type or Print)

(First) **Margaret**  
 (Middle) **S.**  
 (Last) **King**

STREET ADDRESS **411 Maude Ave.**  
 (If rural give location) **Baltimore 25**

4. DATE (Month) **2** (Day) **16** (Year) **1956**

**5. SEX**

**F**

6. COLOR OR  
 RACE **W**

7. SINGLE, MARRIED,  
 WIDOWED, DIVORCED,  
 (Specify) **M**

8. DATE OF BIRTH  
**3/25/62**

9. AGE (at birthday)  
**3** yrs.

10. IF UNDER 1 YEAR  
 Months **0**  
 Days **0**  
 Hours **0**  
 Min. **0**

**10a. USUAL OCCUPATION (Give kind of work  
 done during most of working life, even if  
 retired)**

**Housework**

10b. KIND OF BUSINESS  
 OR INDUSTRY **Home**

11. BIRTHPLACE (State or foreign country)  
**Md.**

12. CITIZEN OF WHAT  
 COUNTRY?

**13. FATHER'S NAME**

**John King**

14. MOTHER'S MAIDEN NAME

**Minnie Josephine**

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
 (Yes, no, or unk.) **No**

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

**1200 E. 46th St.**

18. MEDICAL CERTIFICATION

**I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**

IMMEDIATE CAUSE **(A)** **Hypertensive cardio vascular disease,**

ANTECEDENT CAUSE(S) **(B)** **endarteritis obliterans right leg.**

DISEASES OR CONDITIONS, IF ANY, **(B)**

GIVING RISE TO THE ABOVE CAUSE **(C)**

STATING UNDERLYING CAUSE LAST. **(C)** **Diabetes Mellitus**

INTERVAL BETWEEN  
 ONSET AND DEATH **10/4/52**

**3/53**

?

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
 YES  NO

21a. PLACE (Home, farm, factory,  
 OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County) **Baltimore** (State) **Md.**

21d. TIME OF INJURY (Month) **10** (Day) **4** (Year) **1956** (Hour) **12**

21e. INJURY OCCURRED  
 While  Not while   
 at work  at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **10/4/52, 1956**, to **10/6/56, 1956**, that I last saw the deceased  
 alive on **Feb. 14, 1956**, and that death occurred at **M**, from the causes and on the date stated above.

SIGNATURE **Harry Pepler**

M.D.

ADDRESS **1226 Hanover Street, 2/17/56**

DATE SIGNED **2/17/56**

23. BURIAL, CREMATION,  
 REMOVAL (SPECIFY) **B.**

DATE THEREOF **3/20/56**

NAME OF CEMETERY OR CEMETORY **Cath. L. H. 4**

LOCATION (City, town, or county) **Baltimore**

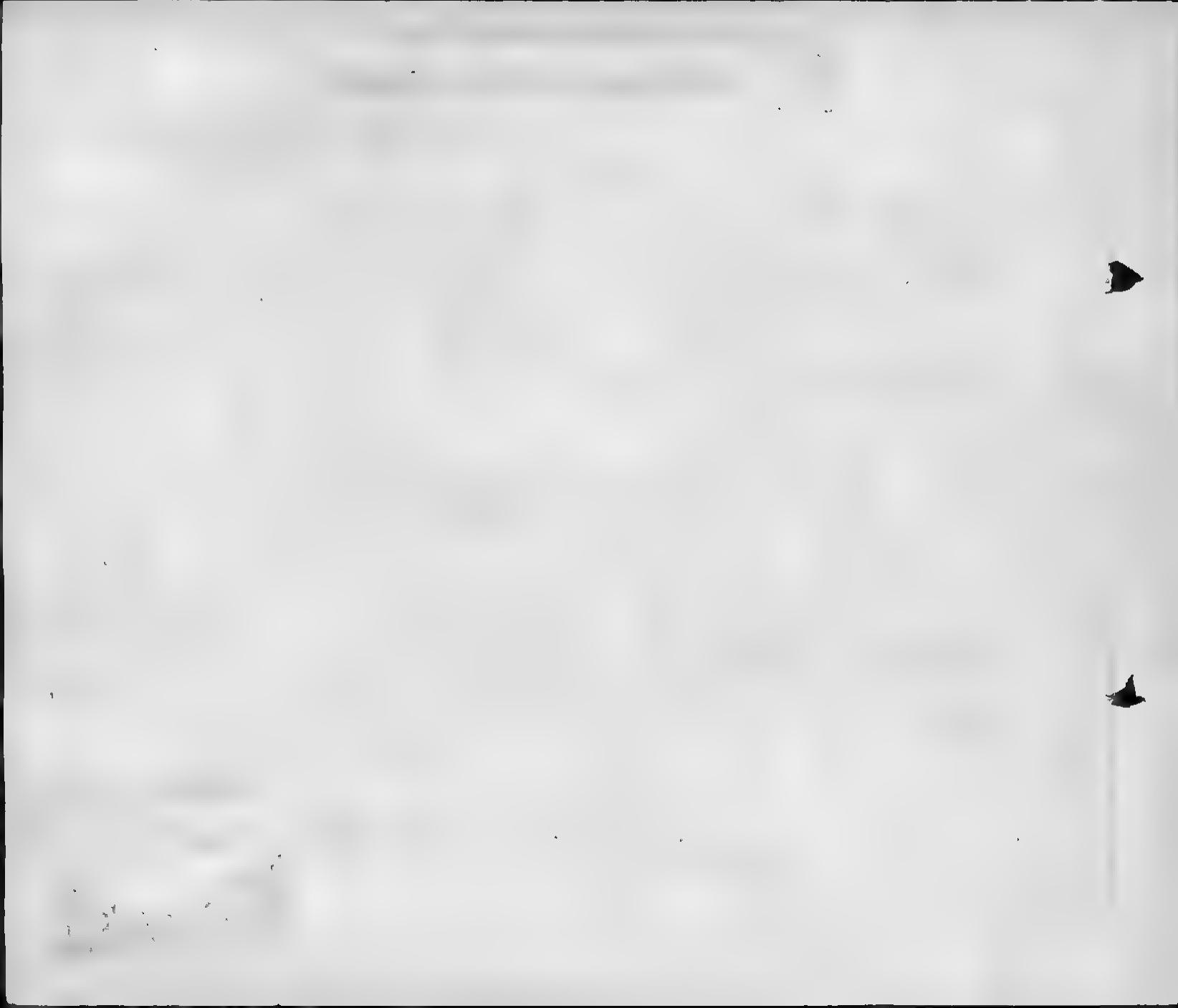
(State) **Md.**

24. REC'D BY REGISTRAR **B. 20 1956**

REGISTRAR'S SIGNATURE **H. Pepler**

25. FUNERAL DIRECTOR'S SIGNATURE **See Cemetery - Funeral Home**

ADDRESS **1226 Hanover Street, 2/17/56**



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 7 days after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-51 10A

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

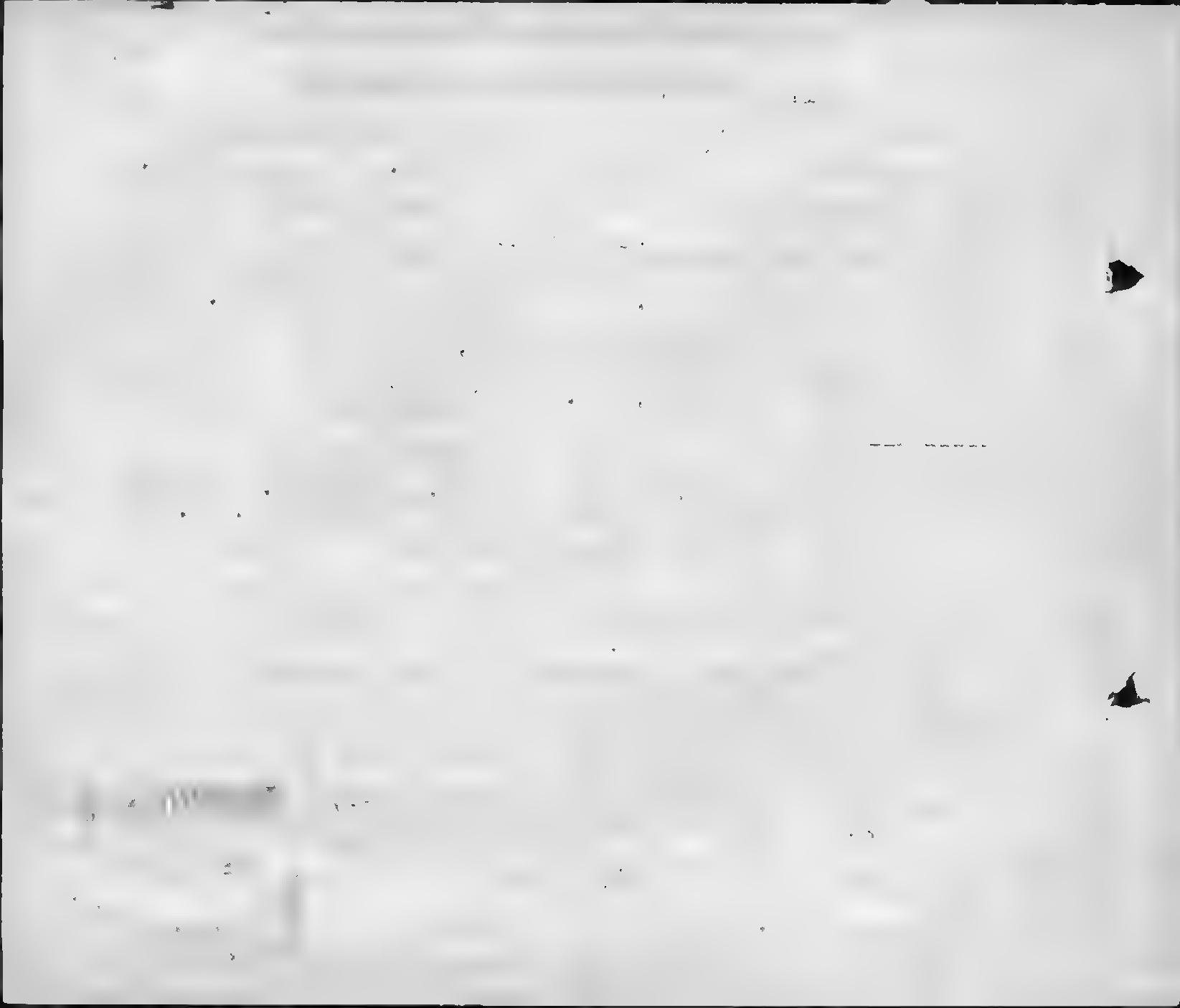
01528

30

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH		2.	
COUNTY Baltimore CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Catonsville		MARYLAND STATE Md. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville	
LENGTH OF STAY (In this place)		COUNTY Balto. STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2403 Old Frederick Rd		2403 Old Frederick Rd	
3. NAME OF DECEASED (First) Edward (Middle) W. (Last) Smith		4. DATE OF DEATH Feb. 17/56 (Month) (Day) (Year)	
5. SEX Male	6. COLOR OR FACE White	7. SINGLE, MARRIED, WIDOWER, DIVORCED (Specify) Married	8. DATE OF BIRTH March 10, 1900
9. AGE last birthday 55 yrs.		10. KIND OF BUSINESS OR INDUSTRY Brinks, Inc.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Messenger		11. BIRTHPLACE (State or foreign country) Wisconsin	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Smith	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) yes no war	
16. SOCIAL SECURITY NO. 579 20 2192		17. INFORMANT & ADDRESS Mrs. Florence F. Smith, 2403 Old	
18. MEDICAL CERTIFICATION Carcinoma (metastatic) liver		19. INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
II DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		20. MEDICAL CERTIFICATION Carcinoma; prostate	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		21. INTERVAL BETWEEN ONSET AND DEATH 2 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work Not while at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8-5, 1955, to 2-17, 1956, that I last saw the deceased alive on 2-17, 1956, and that death occurred at 3 P.M., from the causes and on the date stated above. SIGNATURE Stephen J. J. Koenig, M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 21/56	
NAME OF CEMETERY OR CREMATORIAL Baltimore National		ADDRESS (Street, city, town, state) 908 Frederick Rd., Catonsville, Md. 2-20-56 LOCATION (City, town, or county) Balto. 29, Md. (State)	
24. REC'D BY REGISTRAR DATE		REGISTRAR'S SIGNATURE V. E. Harry	
25. FUNERAL DIRECTOR'S SIGNATURE Harry H. Withey		ADDRESS Edmondson Ave	



## INSTRUCTIONS

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 155 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01529

## 1553 CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town)	COUNTY TOWN STREET ADDRESS (If rural give location)
Baltimore Cockeysville	3 year	Maryland Baltimore	300. 31. Avenue Ave.
3. NAME OF - DECEASED (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH	
Sallie		Feb. 23 1956	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED; WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Female	White	Unknow	July 26, 1872
9. AGE last birthday yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
77	Housewife	Baltimore, Md.	U.S.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Alfred Clatchey	Laura B. Stamberger		
15. HAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS	18. MEDICAL CERTIFICATION
(If Yes, give war or date of service)			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		3 years	
IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO		(A) Enterosclerotic Cardi-Lesional Disease	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO		(B) (C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town)	(County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb. 23, 1956, to Feb. 23, 1956, that I last saw the deceased alive on Feb. 22, 1956, and that death occurred at M, from the causes and on the date stated above. SIGNATURE <i>Walter J. Kies</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIY	LOCATION (City, town, or county)
Burial	Feb. 25, 1956	Loudon Park	Baltimore
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE FEB 27 1956	Jane Macleay	Wm Cook Jr.	1217 St. Paul St.



## INSTRUCTIONS

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M-6-AISC 155-10A

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01500

## 1554 CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH

COUNTY Baltimore

CITY (If outside corporate limits, write RURAL  
OR  
give nearest town)

TOWN Woodlawn

MARYLAND

LENGTH OF STAY  
(In this place)

50 yrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md

COUNTY Balto.

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Woodlawn

STREET ADDRESS  
(If rural give location)

2001 Windsor Place

3. NAME OF  
DECEASED  
(Type or Print)

(First) Annie

(Middle) K.

(Last) Souder

5. SEX

6. COLOR OR  
RACE

F.

W.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)

House Keeper

10b. KIND OF BUSINESS  
OR INDUSTRY

Kelly Clinic

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

Widow

8. DATE OF BIRTH

Oct. 14, 1874

81

yrs.

9. AGE last birthday

4. DATE (Month) (Day) (Year)

Feb. 24

19 56

10. IF UNDER 1 YEAR

Months

Days

Hours

Min.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT  
COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Unknown

## 14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.)

(If Yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

216-10-6216

## 17. INFORMANT &amp; ADDRESS

Mr. I. N. Smith, 602 N. Franklintown

RD

## II DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## IMMEDIATE CAUSE

(A)

ARTERIOSCLEROTIC CARDIOVASCULAR

ANTECEDENT CAUSE(S)  
DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.(B)  
DUE TO  
(C)  
DUE TO

Disease

INTERVAL BETWEEN  
ONSET AND DEATH

3+ yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES  NO 21a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
street, office bldg., etc.)

## 21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

## 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
M. at work  Not white 

## 21f. HOW DID INJURY OCCUR?

M.

at work

at work

White  Not white at work  at work SIGNATURE  
Ivor E. Roach

ADDRESS (Street, city, town, state)

DATE SIGNED  
2/25/66

DATE THEREOF

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county)

(State)

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Feb. 27/56

Loudon Park

Balto. Md.

DATE

REGISTRAR'S SIGNATURE

ADDRESS

1554

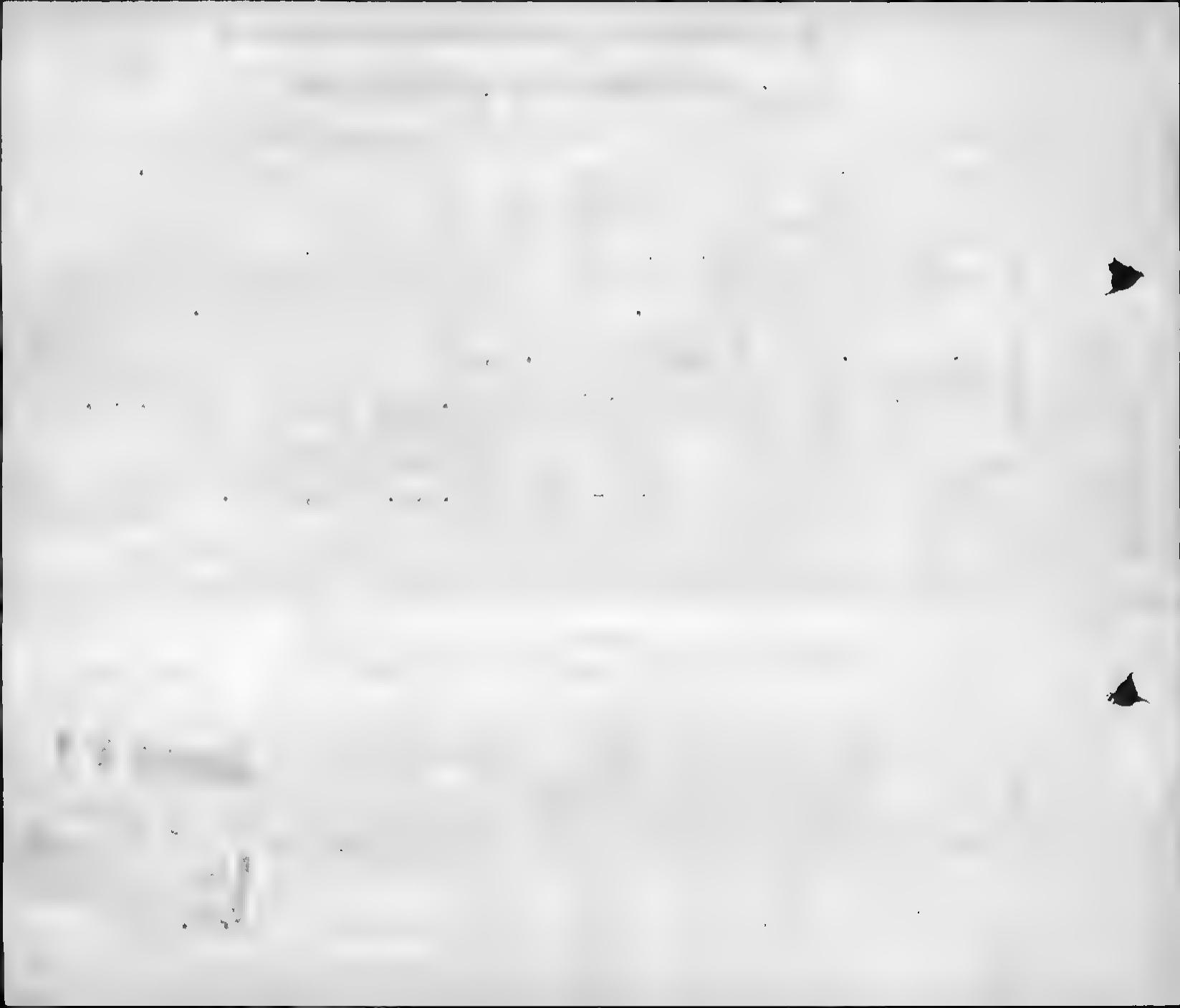
Harry H. Witte

4101 Edmondson Ave

1554

1554

1554



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01531

1398

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

COUNTY BALTO.  
 CITY (If outside corporate limits, write RURAL  
 OR and give nearest town)  
 TOWN ARBUTUS  
 HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS 1244 STEVENS AVE.

MARYLAND  
 LENGTH OF STAY  
 (in this place)  
 34 yrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD. COUNTY BALTO.  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN ARBUTUS

STREET ADDRESS  
 (If rural give location)

1244 STEVENS AVE

## 3. NAME OF DECEASED: (First) (Middle) (Last)

FLORENCE SPIEKER

## 4. DATE (Month) (Day) (Year)

DECEASED: (Type or Print) 2-6 1956

## 5. SEX: 6. COLOR OR RACE: 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)

FEMALE WHITE

## 8. DATE OF BIRTH: 9. AGE last birthday

9-2-1878 77 yrs

## 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

HOUSE WORK

## 10B. KIND OF BUSINESS OR INDUSTRY: AT HOME

## 11. BIRTHPLACE (State or foreign country):

BALTO. MD.

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

WILLIAM HOFFMAN

## 14. MOTHER'S MAIDEN NAME:

ELIZABETH

EDWARD H. SPIEKER

(SAME)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: HUSBAND

EDWARD H. SPIEKER

INTERVAL BETWEEN ONSET AND DEATH

740 -

IMMEDIATE CAUSE (A) DUE TO

6. IMMEDIATE CAUSE (B) DUE TO

7. IMMEDIATE CAUSE (C)

8. IMMEDIATE CAUSE (D)

9. IMMEDIATE CAUSE (E)

10. IMMEDIATE CAUSE (F)

11. IMMEDIATE CAUSE (G)

12. IMMEDIATE CAUSE (H)

13. IMMEDIATE CAUSE (I)

14. IMMEDIATE CAUSE (J)

15. IMMEDIATE CAUSE (K)

16. IMMEDIATE CAUSE (L)

17. IMMEDIATE CAUSE (M)

18. IMMEDIATE CAUSE (N)

19. IMMEDIATE CAUSE (O)

20. IMMEDIATE CAUSE (P)

21. IMMEDIATE CAUSE (Q)

22. IMMEDIATE CAUSE (R)

23. IMMEDIATE CAUSE (S)

24. IMMEDIATE CAUSE (T)

25. IMMEDIATE CAUSE (U)

26. IMMEDIATE CAUSE (V)

27. IMMEDIATE CAUSE (W)

28. IMMEDIATE CAUSE (X)

29. IMMEDIATE CAUSE (Y)

30. IMMEDIATE CAUSE (Z)

31. IMMEDIATE CAUSE (AA)

32. IMMEDIATE CAUSE (BB)

33. IMMEDIATE CAUSE (CC)

34. IMMEDIATE CAUSE (DD)

35. IMMEDIATE CAUSE (EE)

36. IMMEDIATE CAUSE (FF)

37. IMMEDIATE CAUSE (GG)

38. IMMEDIATE CAUSE (HH)

39. IMMEDIATE CAUSE (II)

40. IMMEDIATE CAUSE (JJ)

41. IMMEDIATE CAUSE (KK)

42. IMMEDIATE CAUSE (LL)

43. IMMEDIATE CAUSE (MM)

44. IMMEDIATE CAUSE (NN)

45. IMMEDIATE CAUSE (OO)

46. IMMEDIATE CAUSE (PP)

47. IMMEDIATE CAUSE (QQ)

48. IMMEDIATE CAUSE (RR)

49. IMMEDIATE CAUSE (SS)

50. IMMEDIATE CAUSE (TT)

51. IMMEDIATE CAUSE (UU)

52. IMMEDIATE CAUSE (VV)

53. IMMEDIATE CAUSE (WW)

54. IMMEDIATE CAUSE (XX)

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78. IMMEDIATE CAUSE (VV)

79. IMMEDIATE CAUSE (WW)

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82. IMMEDIATE CAUSE (ZZ)

83. IMMEDIATE CAUSE (AA)

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105. IMMEDIATE CAUSE (WW)

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127. IMMEDIATE CAUSE (SS)

128. IMMEDIATE CAUSE (TT)

129. IMMEDIATE CAUSE (UU)

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153. IMMEDIATE CAUSE (SS)

154. IMMEDIATE CAUSE (TT)

155. IMMEDIATE CAUSE (UU)

156. IMMEDIATE CAUSE (VV)

157. IMMEDIATE CAUSE (WW)

158. IMMEDIATE CAUSE (XX)

159. IMMEDIATE CAUSE (YY)

160. IMMEDIATE CAUSE (ZZ)

161. IMMEDIATE CAUSE (AA)

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171. IMMEDIATE CAUSE (KK)

172. IMMEDIATE CAUSE (LL)

173. IMMEDIATE CAUSE (MM)

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181. IMMEDIATE CAUSE (UU)

182. IMMEDIATE CAUSE (VV)

183. IMMEDIATE CAUSE (WW)

184. IMMEDIATE CAUSE (XX)

185. IMMEDIATE CAUSE (YY)

186. IMMEDIATE CAUSE (ZZ)

187. IMMEDIATE CAUSE (AA)

188. IMMEDIATE CAUSE (BB)

189. IMMEDIATE CAUSE (CC)

190. IMMEDIATE CAUSE (DD)

191. IMMEDIATE CAUSE (EE)

192. IMMEDIATE CAUSE (FF)

193. IMMEDIATE CAUSE (GG)

194. IMMEDIATE CAUSE (HH)

195. IMMEDIATE CAUSE (II)

196. IMMEDIATE CAUSE (JJ)

197. IMMEDIATE CAUSE (KK)

198. IMMEDIATE CAUSE (LL)

199. IMMEDIATE CAUSE (MM)

200. IMMEDIATE CAUSE (NN)

201. IMMEDIATE CAUSE (OO)

202. IMMEDIATE CAUSE (PP)

203. IMMEDIATE CAUSE (QQ)

204. IMMEDIATE CAUSE (RR)

205. IMMEDIATE CAUSE (SS)

206. IMMEDIATE CAUSE (TT)

207. IMMEDIATE CAUSE (UU)

208. IMMEDIATE CAUSE (VV)

209. IMMEDIATE CAUSE (WW)

210. IMMEDIATE CAUSE (XX)

211. IMMEDIATE CAUSE (YY)

212. IMMEDIATE CAUSE (ZZ)

213. IMMEDIATE CAUSE (AA)

214. IMMEDIATE CAUSE (BB)

215. IMMEDIATE CAUSE (CC)

216. IMMEDIATE CAUSE (DD)

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221. IMMEDIATE CAUSE (II)

222. IMMEDIATE CAUSE (JJ)

223. IMMEDIATE CAUSE (KK)

224. IMMEDIATE CAUSE (LL)

225. IMMEDIATE CAUSE (MM)

226. IMMEDIATE CAUSE (NN)

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228. IMMEDIATE CAUSE (PP)

229. IMMEDIATE CAUSE (QQ)

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231. IMMEDIATE CAUSE (SS)

232. IMMEDIATE CAUSE (TT)

233. IMMEDIATE CAUSE (UU)

234. IMMEDIATE CAUSE (VV)

235. IMMEDIATE CAUSE (WW)

236. IMMEDIATE CAUSE (XX)

237. IMMEDIATE CAUSE (YY)



## 1555 CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH

COUNTY BALTIMORE

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR  
and give nearest town)

TOWN FORT HOWARD

LENGTH OF STAY  
(in this place)

6 days

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

VETERANS ADMINISTRATION

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MARYLAND

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR  
TOWN BALTIMORESTREET  
ADDRESS

(If rural give location)

3315 EDMONDSON AVENUE

3. NAME OF  
DECEASED:  
(Type or Print)

DAVID

(Middle)

(NMI)

(Last)

SPRINGER, Jr.

4. DATE (Month)  
OF  
DEATH

(Day)

(Year)

February 12, 1956

## 5. SEX

MALE

6. COLOR OR  
RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED  
(Specify)

SINGLE

## 8. DATE OF BIRTH

8-26-26

## 9. AGE last birthday

29

yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired)10B. KIND OF BUSINESS  
OR INDUSTRY

Laborer

Plywood Corporation

## 11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

## 12. CITIZEN OF WHAT

COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

David Springer, Sr.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates  
of service) P1-28

16. SOCIAL SECURITY NO.

Unknown

## 14. MOTHER'S MAIDEN NAME:

Freida Gephardt

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A)

CEREBRAL EMBOLISM

ANTECEDENT CAUSE (B)

DUE TO

RHEUMATIC HEART DISEASE WITH MITRAL

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

X

STENOSIS

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

CEREBRAL VESSEL ANEURYSM

INTERVAL BETWEEN  
ONSET AND DEATH

6 DAYS

UNKNOWN

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

INTERNAL CAROTID ARTERY

12-10-55; 12-11-55 ARTERIOGRAM &amp; TRACHEOTOMY; EXPLORATION OF RIGHT

## 20. AUTOPSY?

YES  NO 21A. ACCI. IT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County) (State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
While  Not while   
at work  at work 

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 6, 1956 to Feb. 12, 1956, and that death occurred at 3:55 AM.

and that death occurred at 3:55 AM, from the causes and on the date stated above.

SIGNATURE:

C. B. SPRINGER, M.D.

ADDRESS

DATE SIGNED

M.D. VAH, Fort Howard, Md.

2-12-56

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

BURIAL

## DATE THEREOF

Feb. 15/56

## NAME OF CEMETERY OR CREMATORI

Baltimore National

## LOCATION (City, town, or county)

BALTIMORE, MARYLAND

(State)

DATE REC'D BY LOCAL  
REGISTRAR

2-17-56

## REGISTRAR'S SIGNATURE

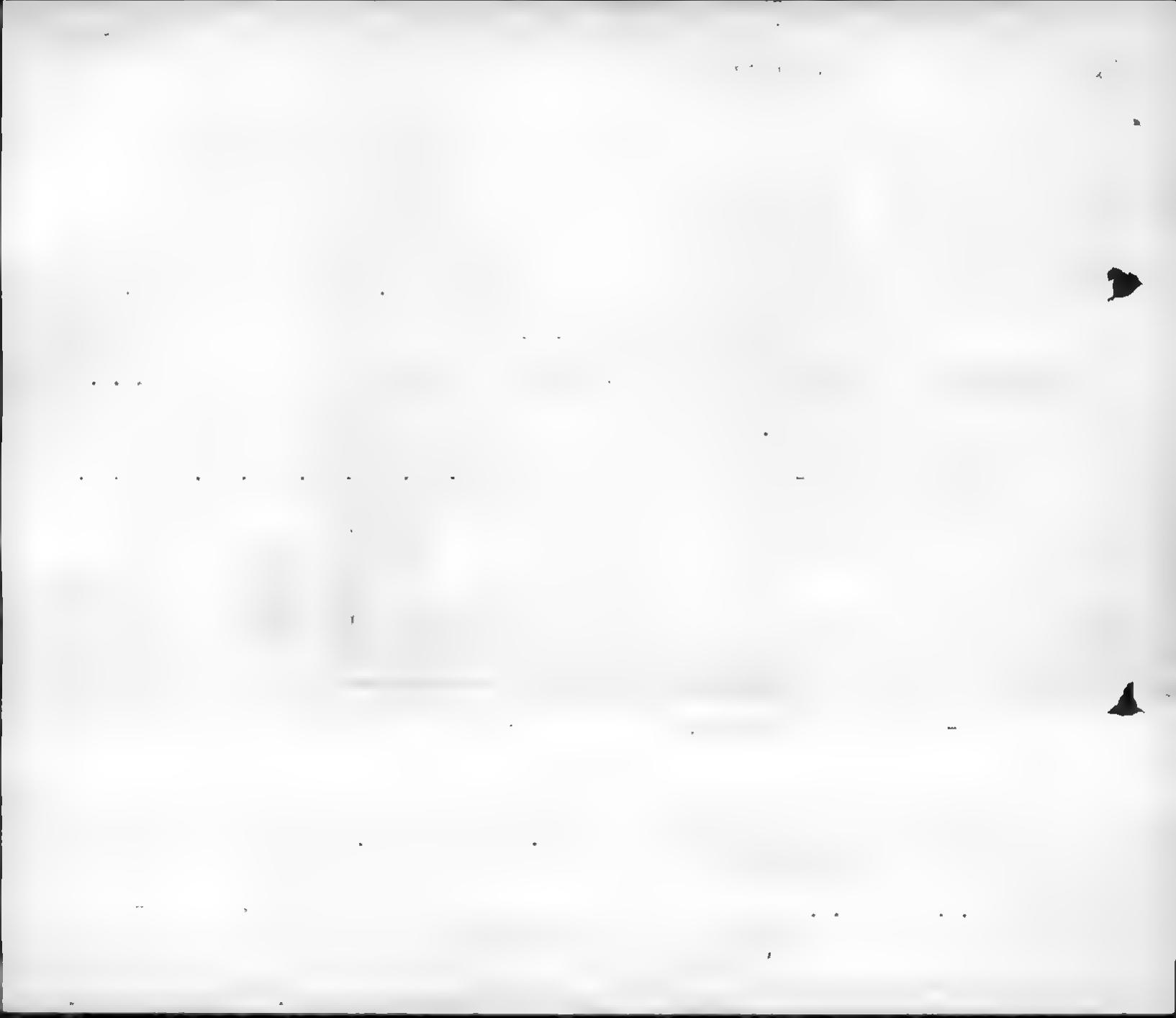
A. S. Springer

## 24. FUNERAL DIRECTOR

WITZKE FUNERAL DIRECTORS

101 Edmondson Ave., Baltimore 29, Md.

ADDRESS



## 1556 CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

COUNTY **Balto.**CITY (If outside corporate limits, write RURAL  
OR and give nearest town)TOWN **Catonsville**

MARYLAND

LENGTH OF STAY  
(in this place)HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

House in the Pines

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Md.**

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN **Baltimore**STREET  
ADDRESS

2733 St. Paul St.

(If rural give location)

3. NAME OF  
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

**JOHN****R. M.****STAUM**

## 5. SEX:

6 COLOR OR  
RACE: **male** **white** 7 SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify): **widowed**

## 8. DATE OF BIRTH:

**Mar. 1, 1873**

9. AGE last birthday

**82**

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS

Days

Hours

Min.

10A USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired):**Lawyer**10B KIND OF BUSINESS  
OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

**Md.**12. CITIZEN OF WHAT  
COUNTRY?

## 13. FATHER'S NAME:

**John Wesley Staum**15. WAS DECEASED EVER IN U.S. ARMED FORCES  
(Yes, no, or unk.) (If Yes, give war or dates  
of service)**no**

16. SOCIAL SECURITY NO.

**none**

## 14. MOTHER'S MAIDEN NAME:

**Juliet Armager**

## 17. INFORMANT &amp; ADDRESS:

**Mr. John W. Staum - 3818 Greenmount Ave.**INTERVAL BETWEEN  
ONSET AND DEATH**5 da**

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

**+91X**

## IMMEDIATE CAUSE

(A) DUE TO

**Broncho-pneumonia**

## ANTECEDENT CAUSE (B)

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.**Ch. Hypertension Cardio-Vascular Disease****15316.1**

19A DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES  NO 21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,  
OR INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
While  Not while   
at work  at work 

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **8-26**, 1955, to **2-16**, 1956, that I last saw the deceased  
alive on **2-16**, 1956, and that death occurred at **10:15 A.M.** from the causes and on the date stated above.  
SIGNATURE **William K. Gallagher**ADDRESS **M. D. Catonsville 28, Md.** DATE SIGNED **2-17-56**23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)  
**Burial**DATE THEREOF  
**2/18/56**NAME OF CEMETERY OR CREMATORIUM  
**Mt. Olivet Cem.**LOCATION (City, town, or county)  
**Balto., Md.** (State)DATE REC'D BY LOCAL  
REGISTRAR  
**February 18, 1956.**REGISTRAR'S SIGNATURE  
**R.W.**24. FUNERAL DIRECTOR  
**Wm. J. Schenck Sons - Balt. 17 Md.**

ADDRESS



## 1557 CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

COUNTY BALTIMORE

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)LENGTH OF STAY  
(in this place)

TOWN CATONSVILLE

2 YEARS, 11 MONTHS

HOSPITAL OR  
INSTITUTION OR SPRING GROVE STATE HOSP.  
STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD.

COUNTY BALTIMORE

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR

TOWN Daniels

STREET  
ADDRESS

(If rural give location)

DANIELS, MD

3. NAME OF  
DECEASED:  
(Type or Print)

ALICE

(Middle)

(Last)

C STEWART

4. DATE (Month)  
OF  
DEATH.

22 1956

## 5. SEX

F

6. COLOR OR  
RACE:

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify):

MARRIED

## 8. DATE OF BIRTH.

?

## 9. AGE last birthday

68

yrs.

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired):

HOUSEWIFE

10B. KIND OF BUSINESS  
OR INDUSTRY:

## 13. FATHER'S NAME:

J. H. WALTER

14. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates  
of service)

No

## 15. SOCIAL SECURITY NO.

UN1500W

16. MEDICAL CERTIFICATION  
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATHINTERVAL BETWEEN  
ONSET AND DEATH44  
IMMEDIATE CAUSE

## (A) CARDIAC FAILURE

2/15/56

DUE TO

## ANTECEDENT CAUSE (B):

## (B) HYPERTENSIVE CARDIO-VASCULAR DISEASE

2/22/56

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

DUE TO

## (C) ARTERIOSCLEROSIS

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH

DIABETES - CONVULSIVE DISORDER

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES  NO 21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
While  Not while   
at work  at work 

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/3 , 1954, to 2/22 , 1956, that I last saw the deceased  
alive on 4/22 , 1956, and that death occurred at 12<sup>th</sup> A.M. from the causes and on the date stated above.

SIGNATURE

Stella Hachler

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION,  
REMOVAL

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county)  
(State)

## Entombed in ground

2/24/56

U. of Md. Med. School

Baltimore, Md.

DATE REC'D BY LOCAL  
REGISTRAR

## REGISTRAR'S SIGNATURE

M. D.

24. FUNERAL DIRECTOR  
ADDRESS

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107

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01535

Item 8 Film Gl93 2-24-56 e CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH.

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
 OR and give nearest town)  
 TOWN Towson (in this place)

HOSPITAL OR STREET ADDRESS 8 Burke Avenue

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Baltimore  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR TOWN Towson  
 STREET ADDRESS (If rural give location)  
 8 Burke Avenue

3. NAME OF (First) (Middle) (Last)  
 DECEASED: CHARLES EDGAR STOVER

4. DATE (Month) (Day) (Year)  
 OF DEATH: February 13, 1956

5. SEX. 6. COLOR OR 7. SINGLE, MARRIED, 8. DATE OF BIRTH 1870 9. AGE last birthday IF UNDER 1 YEAR  
 Male RACE: WIDOWED, DIVORCED, (Specify): Married Sept. 20, 1871 85 yrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life) 10B. KIND OF BUSINESS OR INDUSTRY:  
 Supervisor - retired Steel mfg. co.

11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT COUNTRY?  
 Maryland USA

13. FATHER'S NAME:

Isaac Stever

14. MOTHER'S MAIDEN NAME:

Eleanor Vance

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.  
 (Yes, no, or unk.) (If Yes, give war or dates of service) None None

## 17. INFORMANT &amp; ADDRESS:

Richard Stever, Towson, Maryland

18. MEDICAL CERTIFICATION  
 I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

f.d.s.1

(A) DUE TO

Coronary Thrombosis

INTERVAL BETWEEN  
 ONSET AND DEATH

1 hour

IMMEDIATE CAUSE

(B) DUE TO

Coronary Thrombosis

5 years

ANTECEDENT CAUSE (S)

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
 YES  NO 21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
 (If either, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
 OF INJURY21E. INJURY OCCURRED  
 While  Not while   
 at work  at work 

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1940, 19, to 2-17, 1956 that I last saw the deceased  
 alive on 1-31-1956, and that death occurred at 6 A. M., from the causes and on the date stated above.  
 SIGNATURE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, DATE THEREOF  
 REMOVAL (SPECIFY)

NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)

Burial

Feb. 15, 1956

Mereland Memorial Park

Parkville, Maryland

DATE REC'D BY LOCAL REGISTRAR

Feb. 15, 1956

REGISTRAR'S SIGNATURE

Mabel C. Gray

24. FUNERAL DIRECTOR

John Burns Son, Jr.

ADDRESS

Towson, Maryland

BUREAU V. S.

FEB 13 19

REGELV

## 1399 CERTIFICATE OF DEATH

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

COUNTY BALTIMORE

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR  
and give nearest town)LENGTH OF STAY  
(in this place)

TOWN ARBUTUS

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

8554 SOUTHWESTERN BLVD

3. NAME OF  
DECEASED:  
(Type or Print)

CHARLES F. STRASSER

(First)

(Middle)

(Last)

## 5. SEX:

MALE

WHITE

6. COLOR OR  
RACE:7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify)

MARRIED

8. DATE OF BIRTH:  
May 13, 1875

8. DATE OF BIRTH:

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired)

LETTER CARRIER

10B. KIND OF BUSINESS  
OR INDUSTRY:

POST OFFICE

## 13. FATHER'S NAME:

UNKNOWN

15. WAR DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates  
of service)

No

## 16. SOCIAL SECURITY NO.

218-14-9468

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

22.1

IMMEDIATE CAUSE

Myocardial Failure

INTERVAL BETWEEN  
ONSET AND DEATH

3 days

(A) DUE TO

Arterio Sclerosis -

## ANTECEDENT CAUSE (S)

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY

YES  NO 21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

## 21E. INJURY OCCURRED

## 21F. HOW DID INJURY OCCUR?

M.

While  Not while   
at work  at work 

22. I hereby certify that I attended the deceased from , 1931, to Feb 4, 1956, that I last saw the deceased  
alive on Feb 4, 1956, and that death occurred at 6 P.M., from the causes and on the date stated above.  
SIGNATURE *Frederick D. Becker* ADDRESS *M.D. 1014 Travas Ave - Bldg 27 - 26-16*  
DATE SIGNED *Feb 4, 1956*

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

BURIAL

## DATE THEREOF

2/7/56

## NAME OF CEMETERY OR CREMATORIUM

Loudon Park

## LOCATION (City, town, or county)

BALTIMORE MARYLAND

(State)

DATE REC'D BY LOCAL  
REGISTRAR

Feb 7, 1956

## REGISTRAR'S SIGNATURE

G. A. Hedrich

## 24. FUNERAL DIRECTOR

Joseph S. Smith, Jr., 1328 Sulphur St., Bal.

ADDRESS



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1559 CERTIFICATE OF DEATH

01537

Reg. Dist. No. 35

1. PLACE OF DEATH o COUNTY	Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE	Maryland Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Rural - Parkton		c. LENGTH OF STAY IN 1b	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	20 yrs. -		d. STREET ADDRESS	Rural - Parkton	
Yard Rd.			York Rd.		

3. NAME OF DECEASED (Type or print)	First	Middle	4. DATE OF DEATH	Month	Day	Year
Robert W. Strawbridge			February	25	1956	

5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS		
Male	White	WIDOWED <input checked="" type="checkbox"/>	July 18, 1866	89	Months	Days	Hours	Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Own Farm.	New Park, Pa.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Strawbridge	Eliza Shirey.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No			Mrs. Simon Waltemyer, Parkton, Md. P. O.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	
DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	
(b)	
DUE TO	
(c)	
Cerebral Thrombosis	
arterio sclerosis	
3 days	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
Hour o. m. p. m.	19	White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>				

21. I certify that I attended the deceased from	Feb. 22	, 1956, to	Feb. 25	, 1956, that I last saw the deceased alive on	Feb. 24	, 1956, and that death occurred at 11:30 A.M. from the causes and on the date stated above.
---	---------	------------	---------	---	---------	---

ACTUAL SIGNATURE	Dr. A. M. France M.D.		ADDRESS (Street, city or town, state)	DATE SIGNED
------------------	-----------------------	--	---------------------------------------	-------------

NAME (Type)	Dr. A. M. France	
-------------	------------------	--

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or county)
Burial	Febr. 28, 1956	Center Presby. Cem.	New Park, York Co., Pa.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Jacobi Hartenstein	New Freedom, Pa.	DATE	2/26/56

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

W. O. W.

100

1560

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH

COUNTY BALTIMORE MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR and give nearest town)  
 TOWN FORT HOWARD LENGTH OF STAY  
 (in this place)  
 93 Days

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL

3. NAME OF  
 DECEASED  
 (Type or Print) GEORGE

(First)   
 (Middle) J.

(Last) STROHMER

5. SEX Male 6. COLOR OR  
 RACE White 7. MARRIED,  
 W. BOWED, DIVORCED  
 (Specify) Single

8. DATE OF BIRTH  
April 25, 1890

10A USUAL OCCUPATION (Give kind of  
 work done during most of working life,  
 even if retired) Helper Boiler maker, Steel Co.

10B KIND OF BUSINESS  
 OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Baltimore, Maryland

12 CITIZEN OF WHAT  
 COUNTRY? U. S. A.

## 13. FATHER'S NAME:

John Strohmer

15. WAS DECEASED EVER IN U. S. ARMED FORCES  
 (Yes, no, or unk) Yes (If Yes, give way or dates  
 of service) WW I

14. SOCIAL SECURITY NO. 213-16-3548

## 16. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
 ONSET AND DEATH

## IMMEDIATE CAUSE

(A) BILATERAL HYDRONEPHROSIS AND PYELONEPHRITIS UNKNOWN

## ANTECEDENT CAUSE (S)

DUE TO BENIGN PROSTATIC HYPERPLASIA UNKNOWN

DISEASES OR CONDITIONS, IF ANY,  
 GIVING RISE TO THE ABOVE CAUSE  
 STATING UNDERLYING CAUSE LAST

(B)

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.

## 19A DATE OF OPERATION: 19B MAJOR FINDINGS OF OPERATION

2/13/56 Transurethral Resection of Prostate

20. AUTOPSY?

YES  NO

21A ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
 (If either, NOTIFY MEDICAL EXAMINER)

21B PLACE (Home, farm, factory,  
 OR INJURY street, office bldg., etc.) OF INJURY

21C WHERE DID (City or town)  
 INJURY OCCUR?

(County)

(State)

21D TIME (Month) (Day) (Year)  
 OF INJURY 2/13/56

21E INJURY OCCURRED  
 While  Not while   
 at work  at work

21F HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 18, 1955 to Feb. 19, 1956, and death occurred on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

D. D. MARK, M.D.  
 23. BURIAL, CREMATION,  
 REMOVAL (SPECIFY)  
 Burial

DATE THEREOF 2-22-56

NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county) Baltimore, Maryland

(State)

DATE REC'D BY LOCAL  
 REGISTRAR

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

George Schwab  
 George Schwab Funeral Home 2101 Frederick  
 Ave., Baltimore, Md.



## MARYLAND STATE DEPARTMENT OF HEALTH

01539

1389

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY <b>BALTO</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MD.</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <b>DUNDALK 22</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>DUNDALK 22</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>2604 YORKWAY</b>		STREET ADDRESS <b>2604 YORKWAY</b>	
3. NAME OF DECEASED (Type or Print) <b>ORVILLE</b>	(First) <b>ORVILLE</b>	(Middle) <b>RUSSELL</b>	(Last) <b>SWANN</b>
4. SEX <b>MALE</b>	5. COLOR OR RACE <b>WHITE</b>	6. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	7. DATE OF BIRTH <b>16 MAY 1902</b>
8. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WELDER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>SHIP REPAIR</b>	9. AGE last birthday 53 yrs.	11. BIRTHPLACE (State or foreign country) <b>W. VIRGINIA</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	13. FATHER'S NAME <b>JOHN SWANN</b>	14. MOTHER'S MAIDEN NAME <b>ANNA</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>
16. SOCIAL SECURITY NO. <b>213-09-9489</b>	17. INFORMANT <b>BESSIE B. SWANN</b>	18. MEDICAL CERTIFICATION <i>Coronary Occlusion</i>	19. INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause  Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last  (a) <i>Coronary Occlusion</i>	(b) <i></i>	(c) <i></i>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> OF CAUSE OF DEATH. <input type="checkbox"/> INJURY	PLACE (Home, farm, factory, street, of office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> SIGNATURE <i>Jack Hollens Deputy Medical Examiner Balt 22</i> (Degree or title) <i>ADDRESS</i> DATE SIGNED <i>2-11-52</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>BURIAL</i>	DATE THEREOF <i>2-13-52</i>	NAME OF CEMETERY OR CREMATORIAL <i>ED FELLOWS 2nd m.</i>	LOCATION (City, town, or county) <i>SMYRNA</i> (State) <i>DEL.</i>
DATE REC'D BY LOCAL REG. <i>Feb 12-1952</i>	REG. <i>William M. Kelly</i>	REGISTRAR'S SIGNATURE <i>Wm. M. Kelly</i>	24. FUNERAL DIRECTOR <i>Wm. M. Kelly</i> ADDRESS <i>104</i>



01540

Item 21 Film G193 2-29-56 ans

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

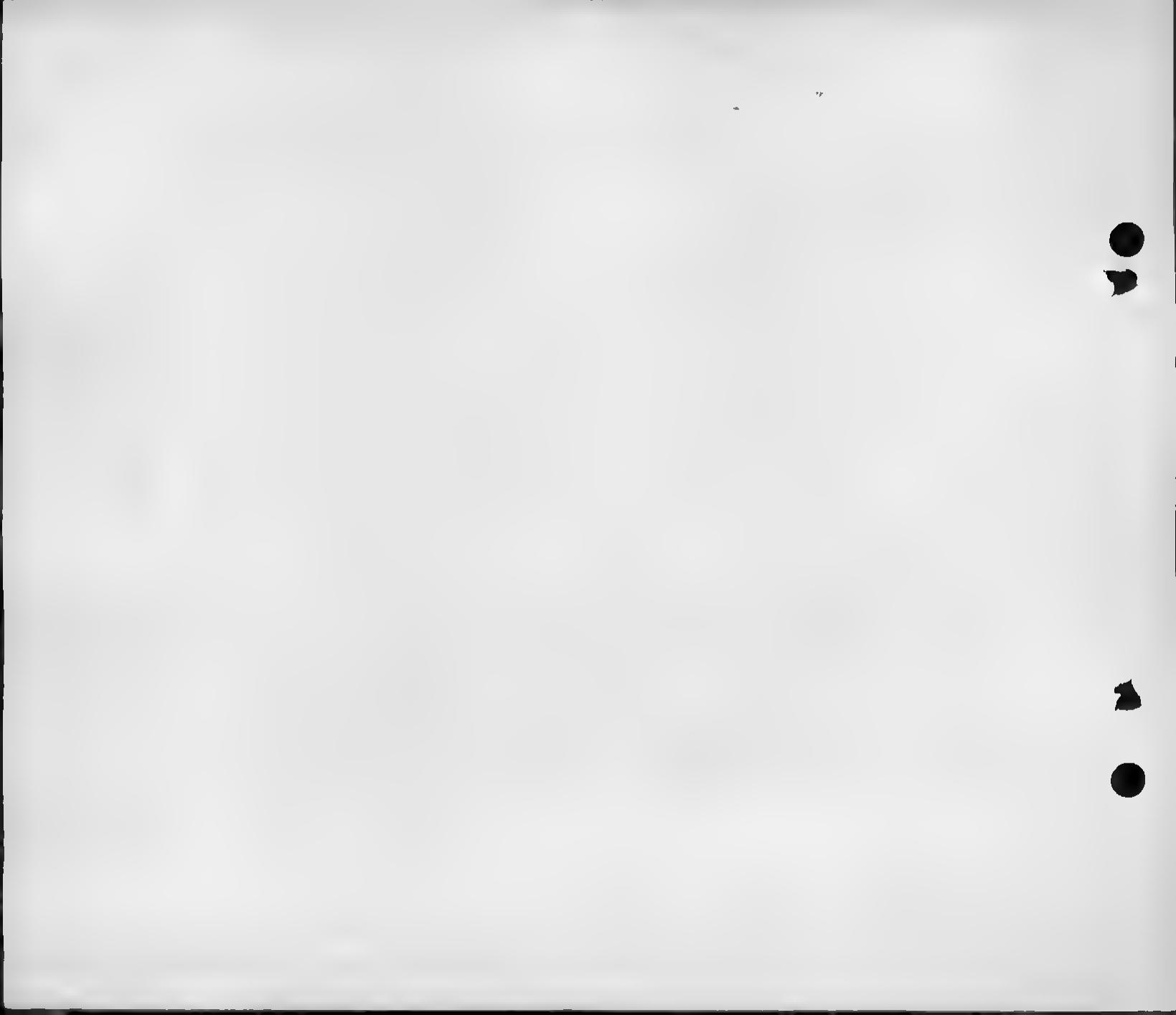
43

Item 12, File 175; 2-27-56 et

**PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>MARYLAND</b>			
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>Fullerton</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>BALTIMORE</b>			
LENGTH OF STAY (in this place)		STREET ADDRESS <b>9223 BELAIR ROAD</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		(If rural, give location)			
3. NAME OF DECEASED (Type or Print)	(First) <b>STANISLAWA-ELIZABETH SZYNKIELENSKI</b>	(Middle)	(Last)		
4. DATE OF DEATH	(Month) <b>2</b>	(Day) <b>14</b>	(Year) <b>1956</b>		
5. SEX	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <b>75</b> yrs.		
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
16. SOCIAL SECURITY NO.					
17. INFORMANT AND ADDRESS <b>M. C. Wilhelm, Daughter</b>					
18. MEDICAL CERTIFICATION					
<p>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>Immediate cause (a) <b>Pulmonary Embolism</b></p> <p>Antecedent cause(s) (b) <b>Intra trochanteric fracture at hip</b></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>resulting in prothrombotic basis</b></p>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION <b>1956</b>		19b. MAJOR FINDINGS OF OPERATION <b>Fracture - Intra trochanteric fracture</b>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21. ACCIDENT SUICIDE HOMICIDE	(Specify) <b>Accident</b>	PLACE (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	(CITY OR TOWN) <b>Fullerton</b>	(COUNTY) <b>Baltimore</b>	(STATE) <b>Md.</b>
TIME (Month) OF INJURY	(Day) 9 56	(Year) 72 m.	(Hour) Work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? Slip & fall down on floor & fall down on
22. I hereby certify that I attended the deceased from <b>9 Jan</b> , 1956, to <b>14 Feb</b> , 1956, that I last saw the deceased alive on <b>14 Feb</b> , 1956, and that death occurred at <b>8:30 A.M.</b> , from the causes and on the date stated above.					
SIGNATURE <b>John C. Dylewski</b>		(Degree or title) <b>1527 Belair Rd Baltimore Md</b>	ADDRESS	DATE SIGNED <b>2/15/56</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>	DATE THEREOF <b>2/17/56</b>	NAME OF CEMETERY OR CREMATORIAL <b>HOLY CROSS CEM.</b>	LOCATION (City, town, or county) <b>BALTIMORE</b>	(State)	
DATE REC'D BY LOCAL REG. <b>2/15/56</b>	REG. NO. <b>10010456</b>	REG. DATE <b>2/17/56</b>	REG. BY <b>John C. Dylewski</b>	FUNERAL DIRECTOR <b>Fred W. Ozarowski</b>	
REG. NO. <b>2/15/56</b>		REG. DATE <b>2/17/56</b>	REG. BY <b>John C. Dylewski</b>	ADDRESS <b>1930 Eastern Ave.</b>	



## 1562 CERTIFICATE OF DEATH

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Baltimore Maryland Jones Creek	STATE CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	Maryland Jones Creek	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	7402 Hammond Road	STREET ADDRESS	7402 Hammond Road	
3. NAME OF DECEASED: Type or Print	(First) MARY	(Middle) E.	(Last) TRACEY	
4. DATE OF DEATH:	Feb. 8,	(Month)	(Day)	(Year) 1956
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Jan. 27, 1900	9. AGE last birthday: IF UNDER 1 YEAR 56 yrs. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): At home		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Baltimore, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Doster		14. MOTHER'S MAIDEN NAME: Gillard		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)   (If Yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.: 17. INFORMANT & ADDRESS: Joseph A. Tracey 7402 Hammond Road.		
18. MEDICAL CERTIFICATION				
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				
<p>42-0</p> <p>Immediate cause (a) ... Coronary Thrombosis</p> <p>Antecedent causes (b) (b) ... Hypertensive Arterosclerosis Heart Disease</p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) ... Bronchial Asthma</p>				
Interval Between Onset And Death 3 months ?				
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT SUICIDE HOMICIDE		(Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)		
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Oct. 25, 1955, to Feb. 8, 1956, that I last saw the deceased alive on Feb. 6, 1956, and that death occurred at 9 AM, Feb. 8, 1956, from the causes and on the date stated above.				
SIGNATURE Dorothy Queen M. D.		ADDRESS 914 7 Street Baltimore, Md. 2/9/56		
DATE SIGNED				
23. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify) Burial		NAME OF CEMETERY OR CREMATORIUM Feb. 11, 1956   Oak Lawn		LOCATION (City, town, or county) (State) Colgate, Md.
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE February 9, 1956   Dawson L. Farber		24. FUNERAL DIRECTOR Ullrich Funeral Home 2112 Dundalk Ave.
ADDRESS				

EB 11-305

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01542

## 1563 CERTIFICATE OF DEATH

Reg. Dist. No. 35

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filed in by the funeral director, the third copy of this death certificate assembly should be retained for use as a burial transit permit.

VS MSC 1-5110M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN end give nearest town)	Baltimore MARYLAND	STATE CITY (If outside corporate limits, write RURAL and give nearest town)	2nd BALTO
HOSPITAL OR INSTITUTION OR STREET ADDRESS Parkton	LENGTH OF STAY (In this place) 10 yrs	STREET ADDRESS Parkton	(If rural give location)
3. NAME OF DECEASED (Type or Print) RICHARD		4. DATE (Month) OF DEATH Feb. 27 1956	
S. SEX M	COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widow	8. DATE OF BIRTH Jan 28-1875
10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farm	9. AGE last birthday 81 yrs.
13. FATHER'S NAME Jacob Tracey		11. BIRTHPLACE (State or foreign country) Md	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		12. CITIZEN OF WHAT COUNTRY USA	
16. SOCIAL SECURITY NO. No		14. MOTHER'S MAIDEN NAME Martha Eggleing	
17. INFORMANT & ADDRESS Mrs Ralph Garrett, Parkton Md		18. MEDICAL CERTIFICATION Cerebral Thrombosis	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH 3 days	
· IMMEDIATE CAUSE (A) _____ ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) _____ (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb. 20, 1956, to Feb. 23, 1956, that I last saw the deceased alive on Feb. 23, 1956, and that death occurred at 8 P.M. from the causes and on the date stated above. SIGNATURE A. M. Francis M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb 27/56	NAME OF CEMETERY OR CREMATORIAL St. Abrahams Luth
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Mrs Howard S. Marisivie	FUNERAL DIRECTOR'S SIGNATURE Edw C Tipton
DATE 2-28-56		ADDRESS Baltimore Co Md	
Mrs Howard S. Marisivie		ADDRESS Edw C Tipton Hampstead Md	

MEKLEJO V. A.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01543

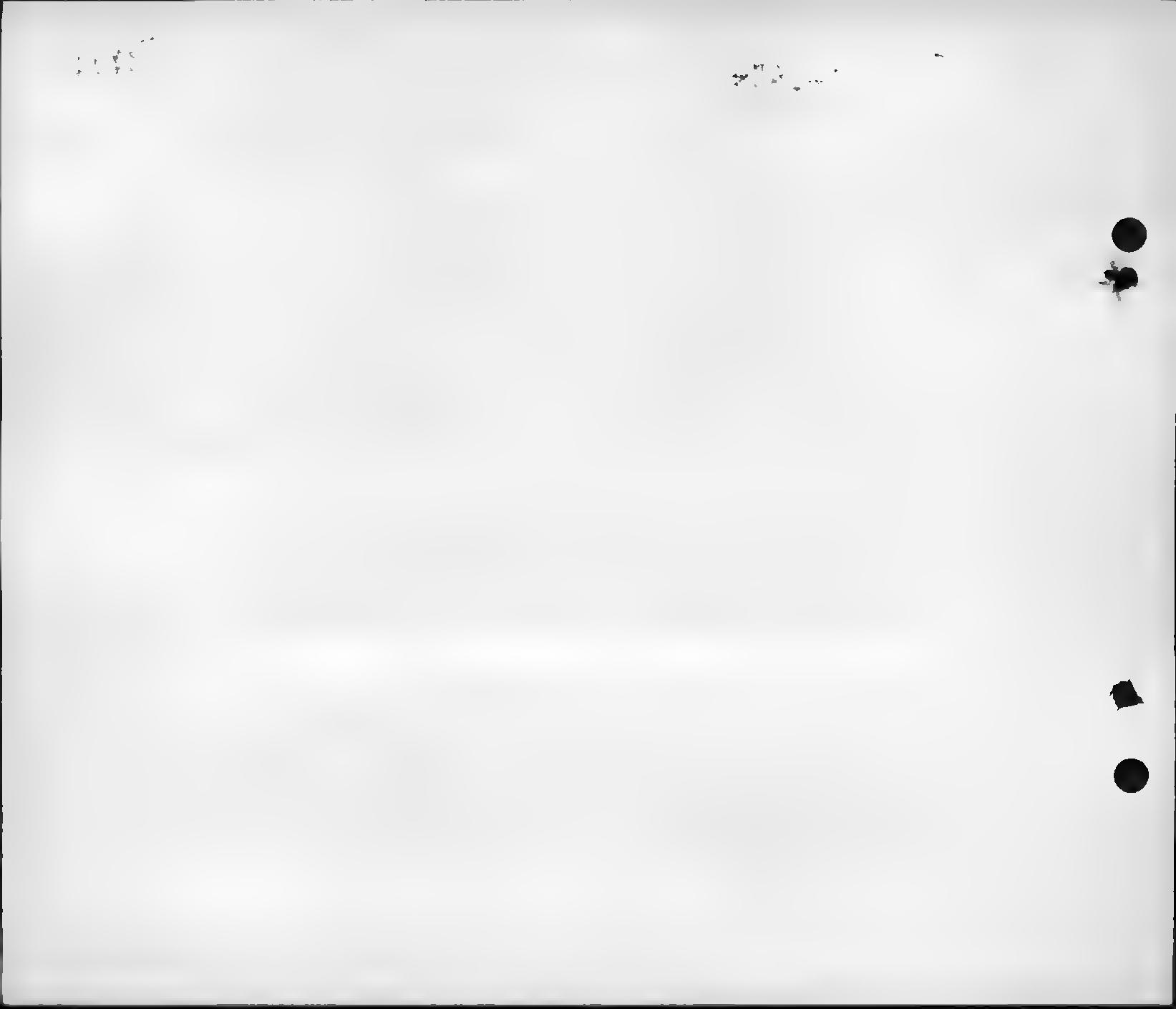
Reg. Dist. No. 40

## 1564 CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Freeland		LENGTH OF STAY (In this place) 5 years	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Freeland	
3. NAME OF DECEASED (Type or Print) Michalina		4. DATE OF DEATH Feb. 2 1956	
(First) (Middle) R. Trczinski (Taylor)		(Month) (Day) (Year)	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH Sept. 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. AGE last birthday 71 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland	
12. FATHER'S NAME John Ratajizak		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-09-0429A	
17. INFORMANT AND ADDRESS Mrs Marie Froelich		18. MEDICAL CERTIFICATION 10 days	
19. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION none	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) OF INJURY	(Day) m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? DATE SIGNED
22. I hereby certify that I attended the deceased from <u>Jan 23</u> , 1956, to <u>Feb 1</u> , 1956, that I last saw the deceased alive on <u>Feb 1</u> , 1956, and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Louis Schatanoff M.D.</u> (Degree or title) ADDRESS <u>New Freedom, Pa.</u> DATE SIGNED <u>2/2/56</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Feb. 6, 1956</u> NAME OF CEMETERY OR CREMATORIAL <u>St. Stanislaus</u> LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State)	
DATE REC'D BY LOCAL REG.		24. FUNERAL DIRECTOR ADDRESS Lilly, & Zeiler Inc., 403 S. Wolfe St.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01544  
1565 CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH COUNTY <b>Balto.</b> MARYLAND CITY: If outside corporate limits, write RURAL OR and give nearest town TOWN <b>Overlea</b>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>Md.</b> COUNTY <b>Balto.</b> CITY: If outside corporate limits, write RURAL and give nearest town OR TOWN <b>Overlea</b>	
3. HOSPITAL, OR INSTITUTION, OR STREET ADDRESS <b>7 Fuller Ave.</b>		4. STREET ADDRESS <b>7 Fuller Ave.</b>	
5. NAME OF DECEASED: (Type or Print) <b>Burleigh E. Turner</b>		6. DATE OF BIRTH <b>1889</b>	
7. SEX <b>M.</b> COLOR OR RACE <b>W.</b> SINGLE, MARRIED, WIDOWED, DIVORCED. 8. <b>Married</b>		9. AGE last birthday <b>66</b> IF UNDER 1 YEAR <b>1</b> OF DEATH <b>Feb. 26, 1956</b> Months Days Hours Min.	
10. USUAL OCCUPATION Give kind of work done during most of working life <b>Clerk</b>		11. KIND OF BUSINESS OR INDUSTRY: <b>Hotel</b>	
13. FATHER'S NAME: <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY: <b>Virginia</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk) <b>No</b> 16. SOCIAL SECURITY NO. <b>216-09-8274</b>		17. INFORMANT & ADDRESS: <b>(Wife) 7 Fuller Ave.</b>	
18. MEDICAL CERTIFICATION <b>Coronary thrombosis Arteriosclerotic coronary heart disease</b>			
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>IMMEDIATE CAUSE</b> <b>Antecedent cause (s)</b> <b>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last.</b>			
20. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
21A. DATE OF OPERATION.		21B. MAJOR FINDINGS OF OPERATION	
21C. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21D. PLACE (Home, farm, factory of INJURY street, office bldg., etc.)	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>M</b>		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> At work <input type="checkbox"/>	
21G. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Feb 20, 1956</b> to <b>Feb 25, 1956</b> that I last saw the deceased alive on <b>Feb 25, 1956</b> and that death occurred at <b>8:30 AM</b> from the causes and on the date stated above. SIGNATURE <b>Charles M. Harr</b> ADDRESS <b>M D 6801 Belair Rd</b> DATE SIGNED <b>Feb 25, 1956</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		24. FUNERAL DIRECTOR NAME OF CEMETERY OR CREMATORIAL LOCATION (In town, or county) <b>Parkwood Cem.</b> Balto. Md.	
DATE PEC'D BY LOCAL REGISTRAR <b>Feb 28, 1956</b>		REGISTRAR'S SIGNATURE <b>Dr. K. A. Harr</b>	
ADDRESS <b>1565</b>		ADDRESS <b>Paul A. Heemann 6067 Harford Rd.</b>	

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11/11/2018

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. ....

## 1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
TOWNLENGTH OF STAY  
(in this place)HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS3. NAME OF  
DECEASED:  
(Type or Print)

(First)

(Middle)

Unidentified Newborn

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md.

COUNTY

CITY (If outside corporate limits write RURAL and give nearest town)  
OR  
TOWNSTREET  
ADDRESS

(If rural, give location)

4. DATE  
OF  
DEATH

(Month) (Day) (Year)

2 1 1956

5. SEX:

6. COLOR OR  
RACE:  
Female White7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify):10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
even if retired):10b. KIND OF BUSINESS OR  
INDUSTRY:

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)

16. SOCIAL SECURITY NO.:

17. INFORMANT &amp; ADDRESS:

18. MEDICAL CERTIFICATION  
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:INTERVAL BETWEEN  
ONSET AND DEATHImmediate cause (a) ... *Anoxia secondary to placenta praevia.*  
DUE TO

Antecedent cause(s)

Diseases or conditions, if any, (b) ....  
giving rise to the above cause DUE TO  
stating underlying cause last (c)II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes  No 21a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING  CAUSE OF DEATH.21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY *XXV*21b. PLACE (Home, farm, factory,  
OF street, office bldg., etc.,  
INJURY *XXV*21e. INJURY OCCURRED  
While at Not while  
work  at work 

21c. (City or town) (County)

(State)

*XXV*

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and  
find that death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined cause   
SIGNATURE *Paul F. Mers*CHIEF MEDICAL EXAMINER  
DEPUTY MEDICAL EXAMINER  
M. D. ASSISTANT MEDICAL EXAM.DATE SIGNED  
*2/2/56*23. BURIAL, CREMATION,  
REMOVAL  
(Specify): *Cremation*DATE THEREOF *1/1/56*

LOCATION (City, town, or county) (State)

DATE REC'D. BY LOCAL  
REG. *1956*REG. *1956*

adV

## 1567 CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
 OR and give nearest town) (in this place)  
 TOWN Fort Howard 9 Days

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS Veterans Administration Hospital

3. NAME OF (First) (Middle) (Last)  
 DECEASED: PERCY (NMI) URIE

5. SEX: Male 6. COLOR OR 7. SINGLE MARRIED.  
 RACE: White W. DOWED, DIVORCED. 8. DATE OF BIRTH:  
 (Specify): Married 9/23/95

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if painter Foreman Gas & Electric Co.

13. FATHER'S NAME:

Samuel H. Uriel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW-I

16. SOCIAL SECURITY NO.

212-05-5133 Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.

11. BIRTHPLACE (State or foreign country): 12 CITIZEN OF WHAT COUNTRY?

Baltimore, Maryland

U.S.A.

14. MOTHER'S MAIDEN NAME:

Annie V. Downey

17. INFORMANT &amp; ADDRESS

INTERVAL BETWEEN  
 ONSET AND DEATH

UNKNOWN

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

292.4

IMMEDIATE CAUSE

(A)

APLASTIC ANEMIA

ANTECEDENT CAUSE (8)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE  
 STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
 YES  NO 21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While  Not while   
 at work  at work 

21F. HOW DID INJURY OCCUR?

VA

M.

22. I hereby certify that I attended the deceased from Feb. 16, 1956, to Feb. 25, 1956, ~~and that death occurred at 8:25 PM, from the causes and on the date stated above.~~

~~and that death occurred at 8:25 PM, from the causes and on the date stated above.~~  
 SIGNATURE *D. MARK* ADDRESS DATE SIGNED

23. BURIAL, CREMATION, DATE THEREOF  
 REMOVAL (SPECIFY) Burial

NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)

Baltimore National Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR

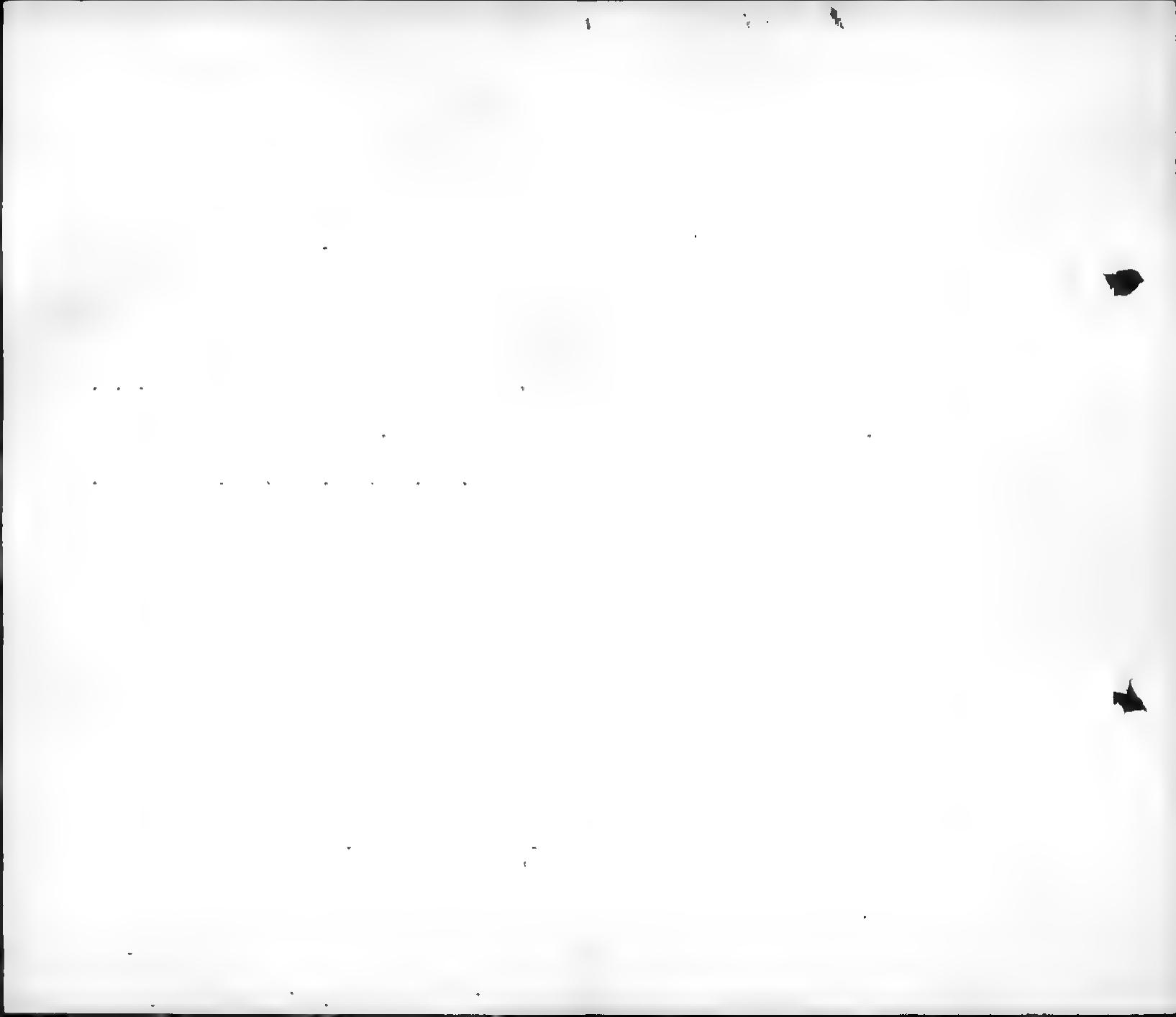
REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

Wm. Cook-Blight, Inc.

ADDRESS

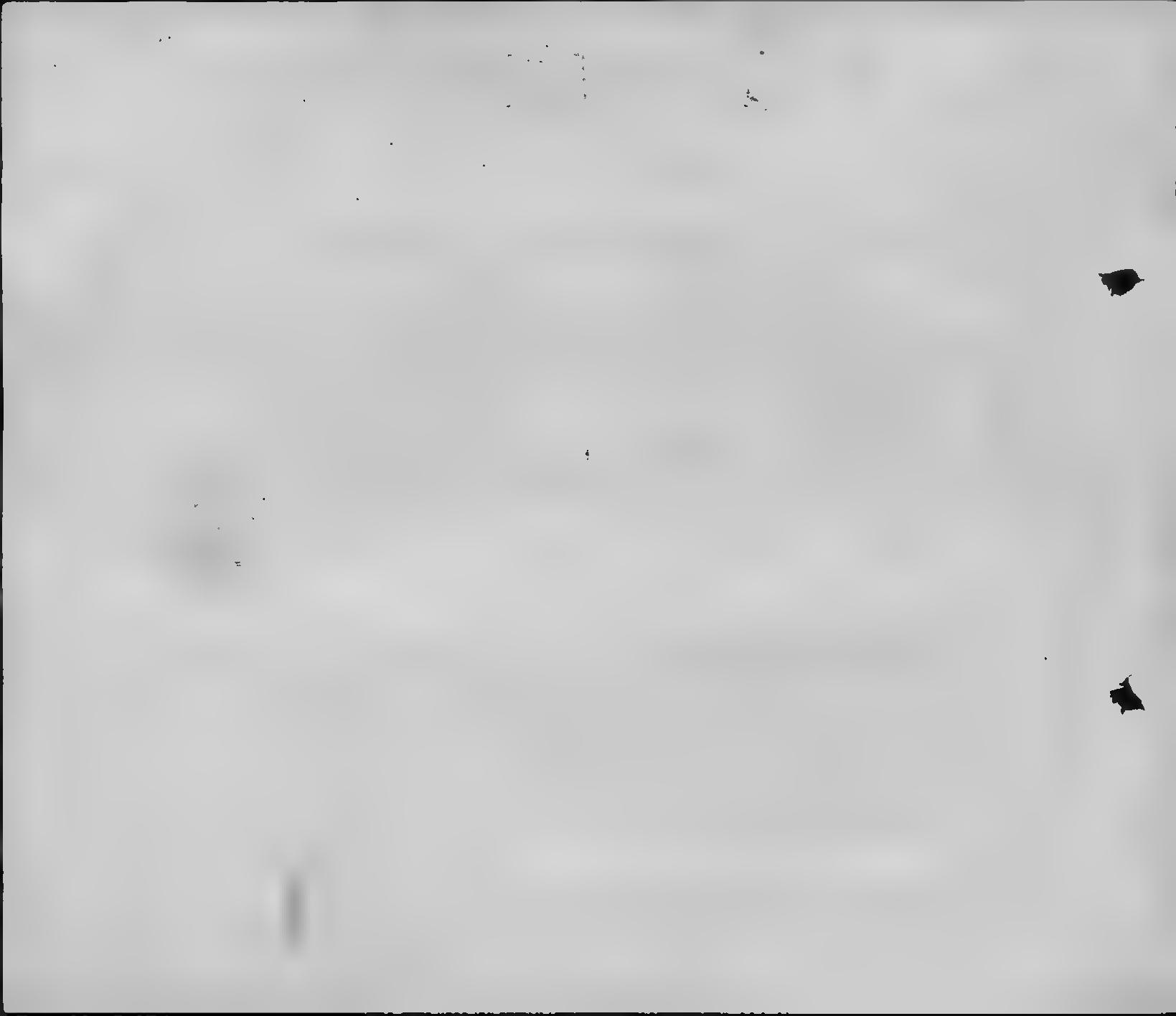
421/56 Q. W. Heebner 191 8009 Harford Rd. Baltimore, Md.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>STARROWS Point</u>		LENGTH OF STAY (in this place) <u>2 Hours</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>BETH STEEL Hospital</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Balto.</u>	
3. NAME OF DECEASED: (Type or Print) <u>ELLSWORTH</u>		STREET ADDRESS <u>301 S. Norris St.</u>	
4. DATE (Month) <u>2</u> (Day) <u>14</u> (Year) <u>1956</u>		(If rural, give location)	
5. SEX: Male RACE: White		6. COLOR OR RACE: <u>Married</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
10a. USUAL OCCUPATION (Give kind of work, or kind of work life, even if retired): <u>TRACTOR TRAILER DRIVER</u>		8. DATE OF BIRTH: <u>May 31-1925</u>	
10b. KIND OF BUSINESS OR INDUSTRY: <u>Construction Co</u>		9. AGE last birthday: <u>29</u> yrs. <u>30</u> months <u>0</u> days	
11. BIRTHPLACE (State or foreign country): <u>OSWALD W. VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William P. VASS</u>		14. MOTHER'S MAIDEN NAME: <u>EVELYN P. TONEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW2 736-76-4890</u>		16. SOCIAL SECURITY NO.: <u>MANOESH P. VASS 301 S. NORRIS ST</u>	
17. INFORMANT & ADDRESS: <u>MANOESH P. VASS 301 S. NORRIS ST</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  Immediate cause (a) ... DUE TO <u>Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
Antecedent cause(s) Diseases or conditions, if any, (b) .... giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>19b. MAJOR FINDING OF OPERATION:</u>		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> SIGNATURE <u>B. Fisher</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>Feb 17-1956</u> NAME OF CEMETERY OR CREMATORIAL <u>TONEY Cemetery</u> LOCATION (City, town, or county) <u>BECKLEY, W. Va.</u> (State) <u>W. Va.</u>	
DATE REC'D BY LOCAL REG <u>2-15-56</u>		REGISTRAR'S SIGNATURE <u>L</u> 2. FUNERAL DIRECTOR <u>B. M. Walter</u> ADDRESS <u>PRAHT &amp; STRICKER INC.</u>	



MARYLAND

1569

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH: COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i> Maryland</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>Pikesville</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Pikesville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>1703 Lintonmore St.</i>		LENGTH OF STAY (in this place) <i>20 years</i>	
3. NAME OF DECEASED (Type or Print) <i>LEIDHINE ELIZABETH VAUGHN</i>		4. DATE OF DEATH <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>9-11-1924</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Alabama</i>		12. CITIZEN OF WHAT COUNTRY? <i>Alabama</i>	
13. FATHER'S NAME <i>John Vaughn</i>		14. MOTHER'S MAIDEN NAME <i>Leah</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-28-9073</i>	
17. INFORMANT AND ADDRESS <i>John Vaughn, 73</i>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATHImmediate cause (a) *Heart disease*Antecedent cause(s) (b) *Arteriosclerosis*Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last (c) *Heart disease*

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *July 1, 1956*, to *July 15, 1956*, that I last saw the deceased  
alive on *July 1, 1956*, and that death occurred at *11:30 a.m.*, from the causes and on the date stated above.  
SIGNATURE *Dorothy Newell* ADDRESS *1703 Lintonmore St., Baltimore, Md.* DATE SIGNED *July 15, 1956*

23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE <i>Feb. 18, 1956</i>	NAME OF CEMETERY OR CREMATORIAL <i>Gator's Baptist Cemetery</i>	LOCATION (City, town, or county) <i>Lutherville, Baltimore, Md.</i> (State) <i>Md.</i>
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REG. <i>Feb. 27, 1956 Dorothy Newell</i>		24. FUNERAL DIRECTOR ADDRESS <i>John Burns Son, Towson, Maryland</i>	

Y. S.

FEB 9 1977

REGELY

## MARYLAND STATE DEPARTMENT OF HEALTH

01549

1570 CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

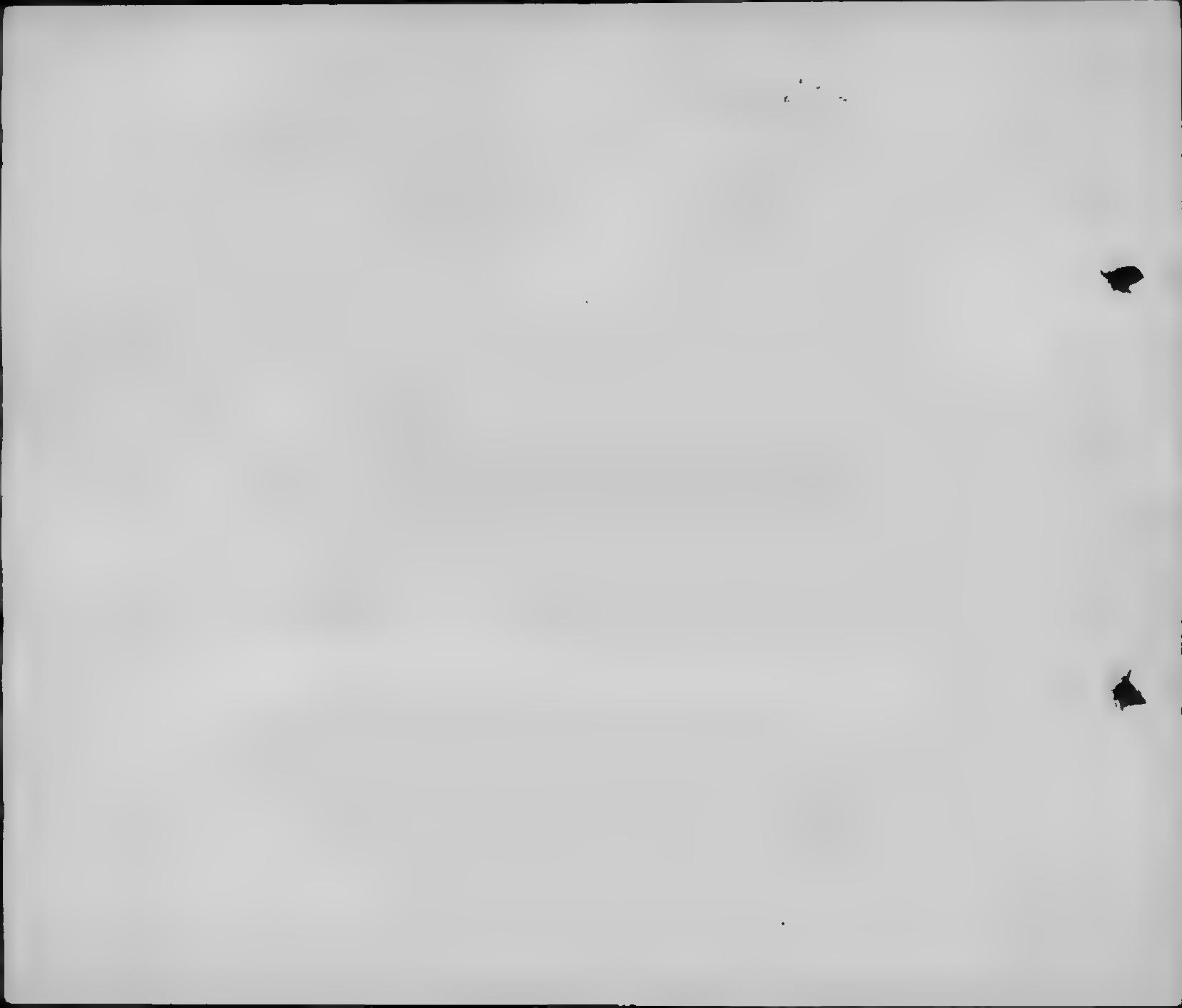
Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Baltimore</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baltimore</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>1559 Homestead Street</i>		STREET ADDRESS <i>1559 Homestead Street #18</i>	
3. NAME OF DECEASED (Type or Print) <i>Mrs. Josephine B.</i>		4. DATE OF DEATH <i>February 18th 1956</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH <i>Mar. 1, 1899</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>Mr. August Michael Walther, 1559 Homestead</i>	
17. INFORMANT AND ADDRESS <i>Mr. August Michael Walther, 1559 Homestead</i>			
18. MEDICAL CERTIFICATION			
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  Immediate cause (a) ....  Antecedent cause(s) Diseases or conditions, if any, (b) .... giving rise to the above cause stating the underlying cause last  (c) ....			
20. AUTOPSY?  Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EX. FINAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>INJURY</i>	(CITY OR TOWN)  (COUNTY)  (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/>	HOW DID INJURY OCCUR?  <i>falling</i>
22. I certify, that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined SIGNATURE (Degree or title) ADDRESS DATE SIGNED <i>St. Agnes Hospital</i>			
DATE OF DEATH (Local time)		DATE THEREOF NAME OF CEMETERY OR CREMATORIUM LOCATION (City, town, or county)  <i>Burial</i> <i>Feb. 21, 1956</i> <i>Baltimore National Cem.</i> <i>Baltimore, Maryland</i> (State)	
DATE REGD. BY LOCAL <i>Feb. 21, 1956</i>		REGISTRAR'S SIGNATURE <i>W. C. Redick</i>	
24. FUNERAL DIRECTOR <i>Leonard J. Ruck, 5305 Harford Road #14</i>		ADDRESS	

MARGIN RESERVED FOR BINNING

AS E WRITTEN MAINLY WITH UNFADING INK. Supply every item of information carefully. The correct  
is especially important. Physicians, please write the causes of death clearly and legibly.

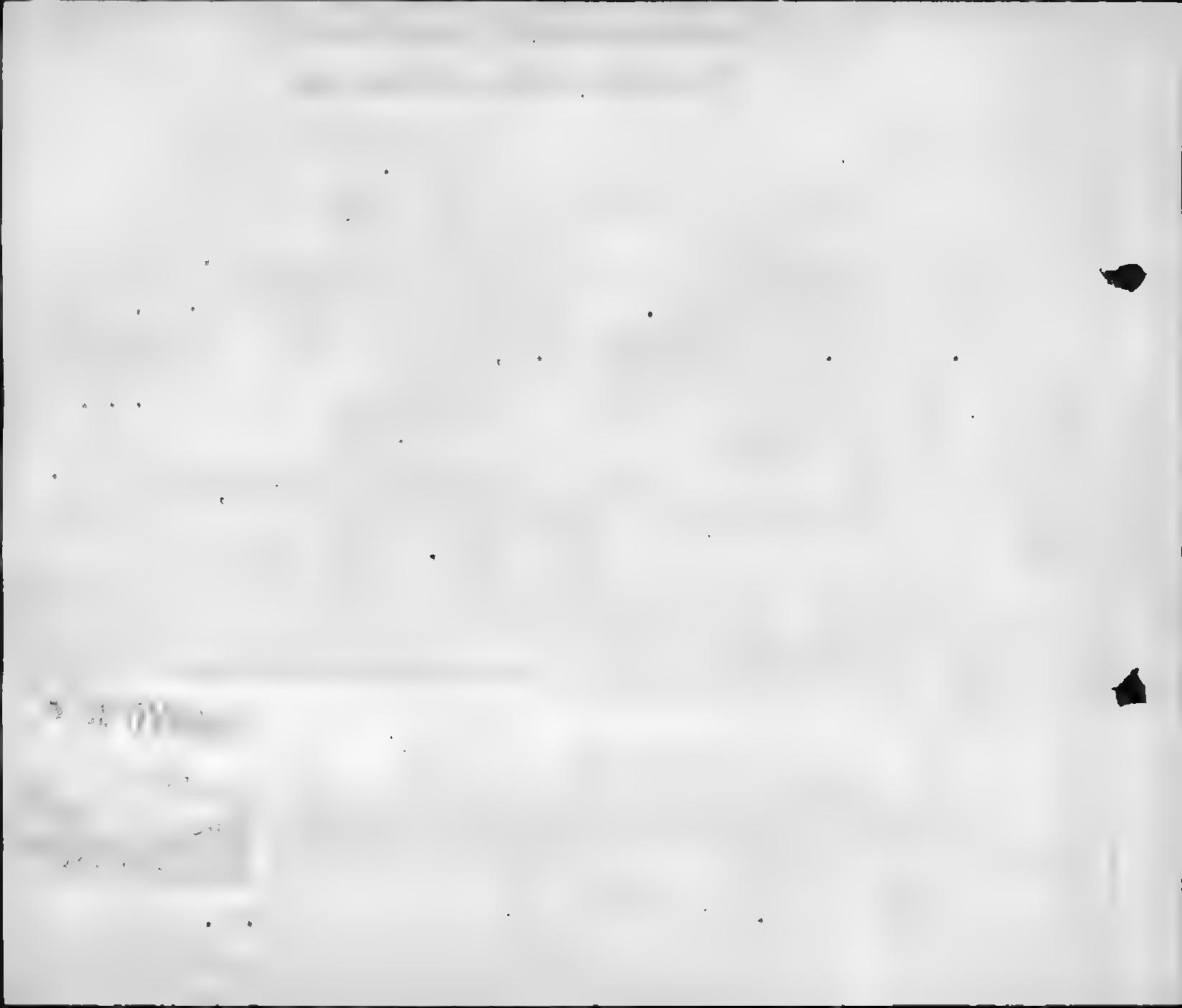
VS ALA



## 140 CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED				
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN TOWN)	Baltimore Arbutus	MARYLAND LENGTH OF STAY (In this place)	STATE Md. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS	1050 Downton Rd.	STREET ADDRESS	Arbutus (If rural give location)			
3. NAME OF DECEASED (Type or Print)	George E. Ward	(First) (Middle) (Last)	4. DATE OF DEATH (Month) (Day) (Year)			
5. SEX M.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH Jan. 29, 1898	9. AGE last birthday 58 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas Ward		14. MOTHER'S MAIDEN NAME Laura				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs Doris Ruediger, 1050 Downton Rd.		
18. MEDICAL CERTIFICATION IMMEDIATE CAUSE (A) <u>Arteriosclerotic Encephalopathy</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) <u>with Cerebral Arteriosclerosis 9 months</u> GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)				INTERVAL BETWEEN ONSET AND DEATH 7 DAYS		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH BRONCHOPNEUMONIA BILATERAL						
19a. DATE OF OPERATION Dec. 1955		19b. MAJOR FINDINGS OF OPERATION Arteriosclerotic Encephalopathy		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from JANUARY 1956, to FEBRUARY 1956, that I last saw the deceased alive on FEB. 4, 1956, and that death occurred at 5:40 P.M. from the causes and on the date stated above. SIGNATURE <u>Melvin H. Borden</u> M.D. ADDRESS (Street, city, town, state) DATE SIGNED 5000 Old Frederick Rd Baltimore 2/7/56						
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 8/56	NAME OF CEMETERY OR CREMATORIAL Loudon Park	LOCATION (City, town, or county) (State) Balto. Md.		
24. REC'D BY REGISTRAR DATE FEB. 8 1956		REGISTRAR'S SIGNATURE Dr. Geo. S. M. Luffing	25. FUNERAL DIRECTOR'S SIGNATURE Dr. Geo. S. M. Luffing		ADDRESS 101 Edmondson Ave.	



01551

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1571

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore MARYLAND		STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Towson		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Towson	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1836 Loch Shiel Road		STREET ADDRESS (If rural give location) 1836 Loch Shiel Road	
3. NAME OF DECEASED: (Type or Print) MAURICE HARDESTY WARD		4. DATE (Month) (Day) (Year) OF DEATH: February 3, 1956	
5. SEX: Male RACE: White		6. COLOR OR 7. SINGLE, MARRIED, RACE: WIDOWED, DIVORCED, (Specify): Married	
8. DATE OF BIRTH: October 30, 1888		9. AGE last birthday 67 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, Ice cream vendor: retired		10B. KIND OF BUSINESS OR INDUSTRY: Self employed	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Asa Ward		14. MOTHER'S MAIDEN NAME: Ida E. Hardesty	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS: Mrs. Mattie P. Ward, Towson, Maryland		INTERVAL BETWEEN ONSET AND DEATH 72 hrs	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) DUE TO Cerebral Thrombosis			
ANTECEDENT CAUSE (B) DUE TO Generalized Atherosclerosis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Very premature for age 6 yrs			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 1949</u> to <u>February 1956</u> that I last saw the deceased alive on <u>February 3 1956</u> , and that death occurred at <u>58 M</u> , from the causes and on the date stated above. SIGNATURE <u>Charles F. Donnell</u> ADDRESS <u>M. D. 2501 Loch Rd - Towson Md 21204</u> DATE SIGNED <u>Feb. 6, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 6, 1956	
NAME OF CEMETERY OR CREMATORIUM Prospect Hill Cemetery		LOCATION (City, town, or county) (State) Towson, Maryland	
DATE REC'D. BY LOCAL REGISTRAR'S SIGNATURE REGISTRAR <u>2/7/56 G. M. Bacon</u>		24. FUNERAL DIRECTOR ADDRESS John Burns' Sons, Towson, Maryland	

100% 8

113

100% 8

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ASEC 1-55

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

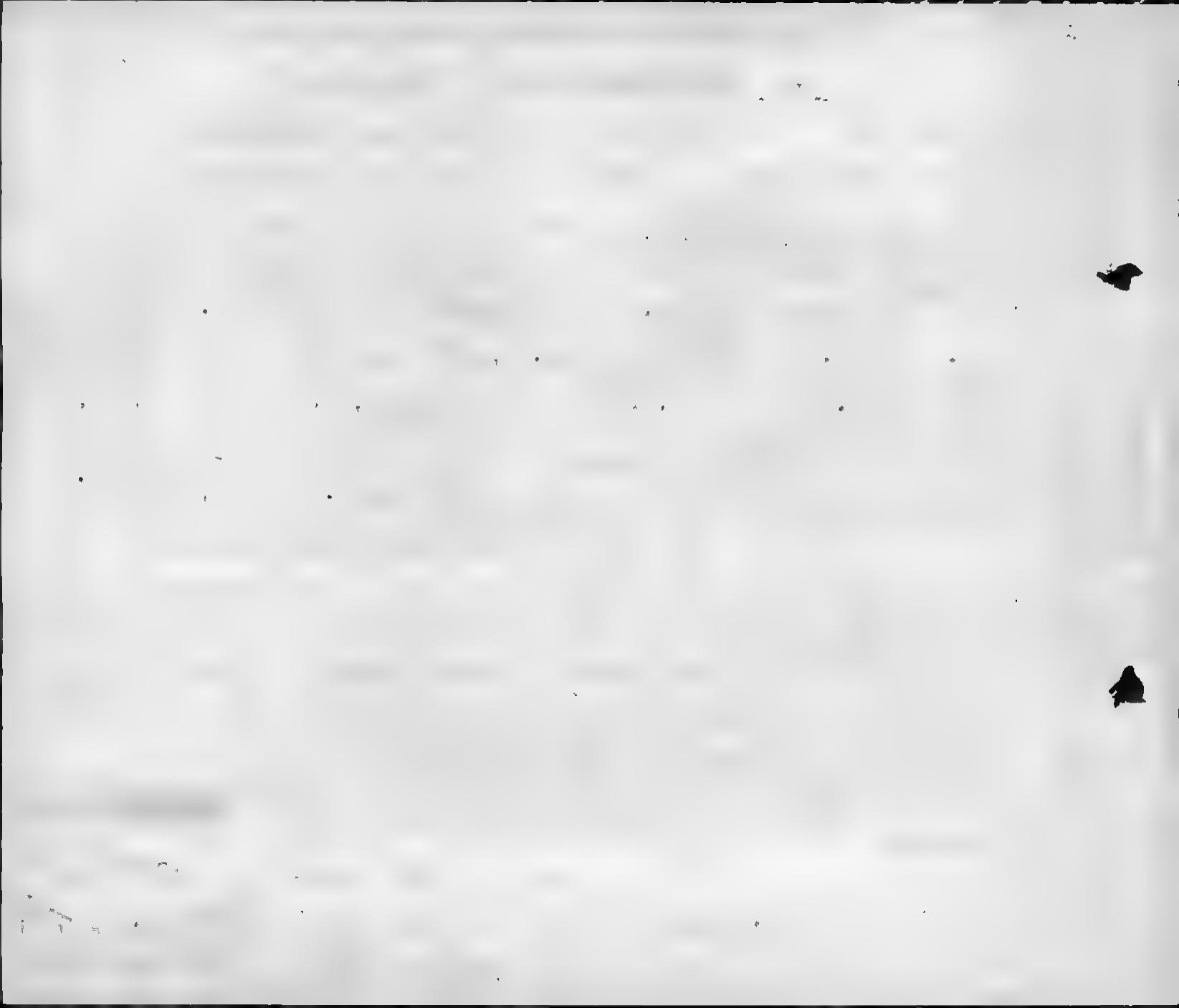
01552

1572

**CERTIFICATE OF DEATH**

Reg. Dist. No. 30

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>					
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		MARYLAND LENGTH OF STAY (in this place)		STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		COUNTY STREET ADDRESS (If rural give location)			
Baltimore		Catonsville		Md.		Owings Mills Md.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		House In The Pines 16 Fusting Ave		STREET ADDRESS		Owings Mills Md.			
<b>3. NAME OF DECEASED (Type or Print)</b>				<b>4. DATE OF DEATH</b>					
Grace E. Wareheim				Feb. 22 1956					
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
F.	W.	Married	Aug. 15, 1874	81 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
H. W.		O.H.		Baltimore, Md.				U.S.A.	
13. FATHER'S NAME				14. MOTHER'S M AIDEN NAME					
John Walsh				Mary Tucker					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS					
(If Yes, give war or dates of service)				Theodore E. Wareheim, Owings Mills Md.					
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>									
<p>IMMEDIATE CAUSE (A) <u>ARTERIO SCLEROSIS TRAUMA CRANICUS</u></p> <p>ANTECEDENT CAUSE(S) DUE TO (B) <u>DISEASE - CEREBRAL SCLEROSIS</u></p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATEMENT UNDERLYING CAUSE LAST. DUE TO (C) <u>TERMINIC PNEUMONIA - CEREBRUM</u></p> <p><u>DYNEORTICARIC MALARIA</u></p>									
INTERVAL BETWEEN ONSET AND DEATH									
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			21c. WHERE DID INJURY OCCUR? (City or town)			(County)	(State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. at work      White      Not white      at work			21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>2/1</u> , 19 <u>56</u> , to <u>2/22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/22</u> , 19 <u>56</u> , and that death occurred at <u>10:15 A.M.</u> from the causes and on the date stated above.									
SIGNATURE <u>John H. Shaw</u> M.D. <u>5800 Edmondson Ave</u>									DATE SIGNED <u>2/24/56</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORI			LOCATION (City, town, or county)		
Burial		Feb. 25/56		Druid Ridge			Pikesville Md.		
24. REC'D BY REGISTRAR DATE		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			ADDRESS		
FFB 27 1956		J. E. Harry		Harry H. White			4101 Edmondson Ave		



**TO ATTENDING PHYSICIAN OR HOSPITAL** The law requires that the death certificate be executed within 24 hours after death. After this copy may be retained by the hospital or attending physician.

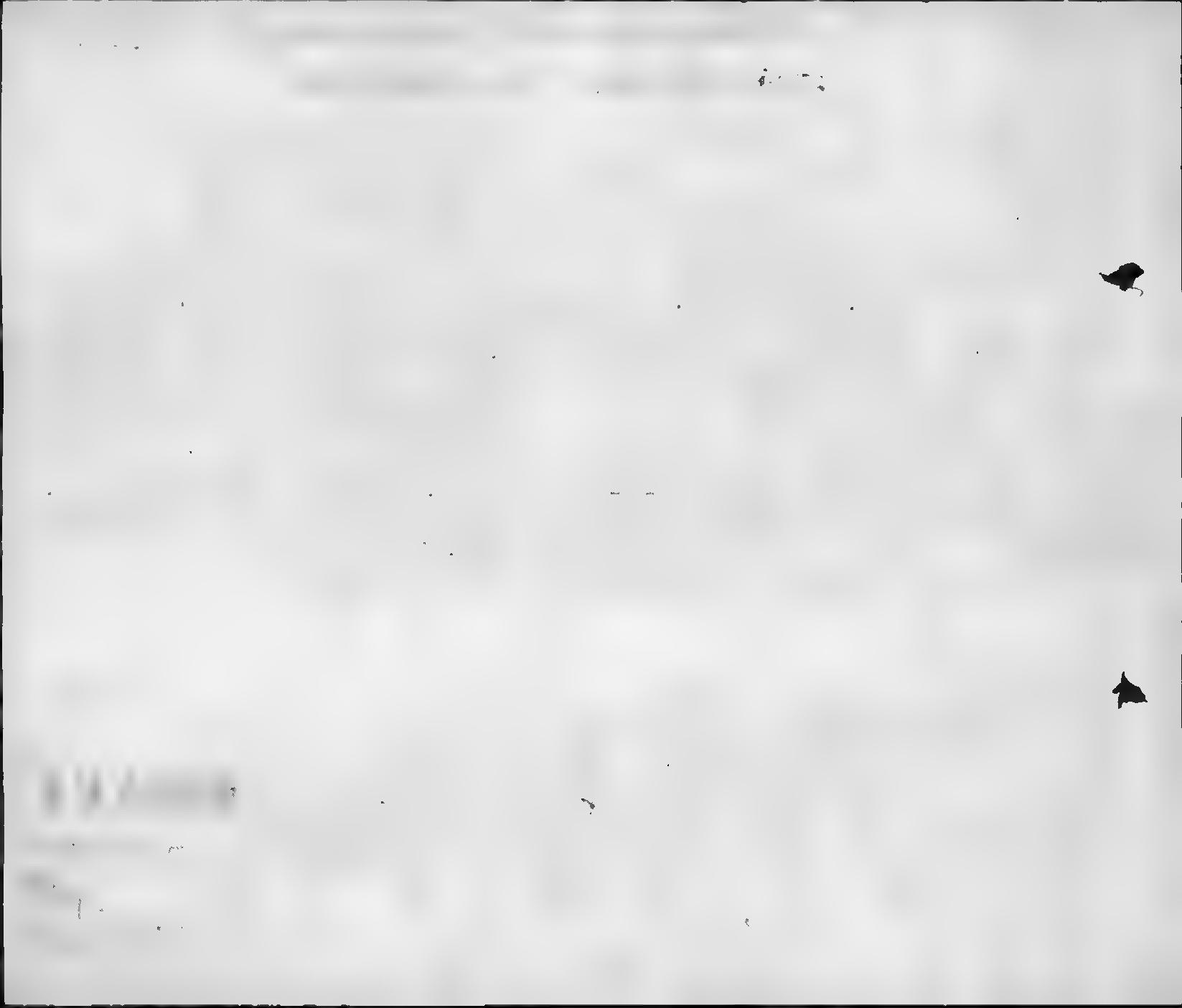
**TO FUNERAL DIRECTOR** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this copy has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained for use as a burial permit.

VS ASC 155.10M

## 1573 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)	Baltimore Parkville 3011 Hiss Avenue	MARYLAND LENGTH OF STAY (In this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parkville STREET ADDRESS (If rural give location)
3. NAME OF DECEASED (Type or Print)		(First) Mr. Lloyd A. Westley (Middle) (Last)	4. DATE OF DEATH Feb. 1, 1956
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH May 25, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool & Dye Worker		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 69 yrs.
13. FATHER'S NAME Henry Westley		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. 212-10-9595	12. CITIZEN OF WHAT COUNTRY USA
17. INFORMANT & ADDRESS Mrs. Mildred Westley, 3011 Hiss Ave.		14. MOTHER'S MAIDEN NAME Ida Raine	18. MEDICAL CERTIFICATION <i>coronary thrombosis arteriosclerotic CVD</i>
II DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		INTERVAL BETWEEN ONSET AND DEATH <i>1/2 hour</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from alive on <u>2/1/1956</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above. SIGNATURE <i>Harold A. Grotz</i>		ADDRESS (Street, city, town, state) <i>M.D. 5100 Harford Rd #11</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb 4, 1956	NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery
24. REC'D BY REGISTRAR DATE		REGISTRAR'S SIGNATURE <i>Dr. A. M. Bacon</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Leonard J. Ruck, 5305 Harford Road #11



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01554

## 1574 CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

Balto.

MARYLAND

CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
OR and give nearest town) (in this place)

TOWSON

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

1718 Redwood Ave.

3. NAME OF  
DECEASED:  
(Type or Print)

WILSON

M.

WHALEY

## 4. DATE (Month) (Day) (Year)

Feb. 10, 1956

## 5. SEX:

male

6. COLOR OR  
RACE:

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify):

married

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired):

Draftsman

10B. KIND OF BUSINESS  
OR INDUSTRY:

Bethlehem Steel

## 11. BIRTHPLACE (State or foreign country):

Md.

12. CITIZEN OF WHAT  
COUNTRY?

## 13. FATHER'S NAME:

Edward N. Whaley

## 14. MOTHER'S MAIDEN NAME:

Lillian M. Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES  
(Yes, no, or unk.) (If Yes, give war or dates  
of service)

no

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS:

Mrs. Pearl D. Whaley - 1718 Redwood Ave

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## IMMEDIATE CAUSE

## (A) DUE TO

Massive Cerebral Hemorrhage

INTERVAL BETWEEN  
ONSET AND DEATH

Instant

## ANTECEDENT CAUSE (S):

## (B) DUE TO

Slight Cerebral Hemorrhage

1949

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

## (C) DUE TO

(C) Generalized Arteriosclerosis

?

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

Hypertension

?

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES  NO 21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH21B. PLACE (Home, farm, factory  
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County) (State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
While  Not while   
at work  at work 

## 21F. HOW DID INJURY OCCUR?

## 22. I hereby certify that I attended the deceased from 6-25-1954 to 2-10-1956 that I last saw the deceased

alive on 2-10-1956, and that death occurred at 6:45 PM, from the causes and on the date stated above.

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

Burial

## DATE THEREOF

2/13/56

## NAME OF CEMETERY OR CREMATORIUM

David Ridge Cem.

## LOCATION (City, town, or county) (State)

Pikesville, Md.

DATE REC'D BY LOCAL  
REGISTRAR

## REGISTRAR'S SIGNATURE

February 11 1956 RCR

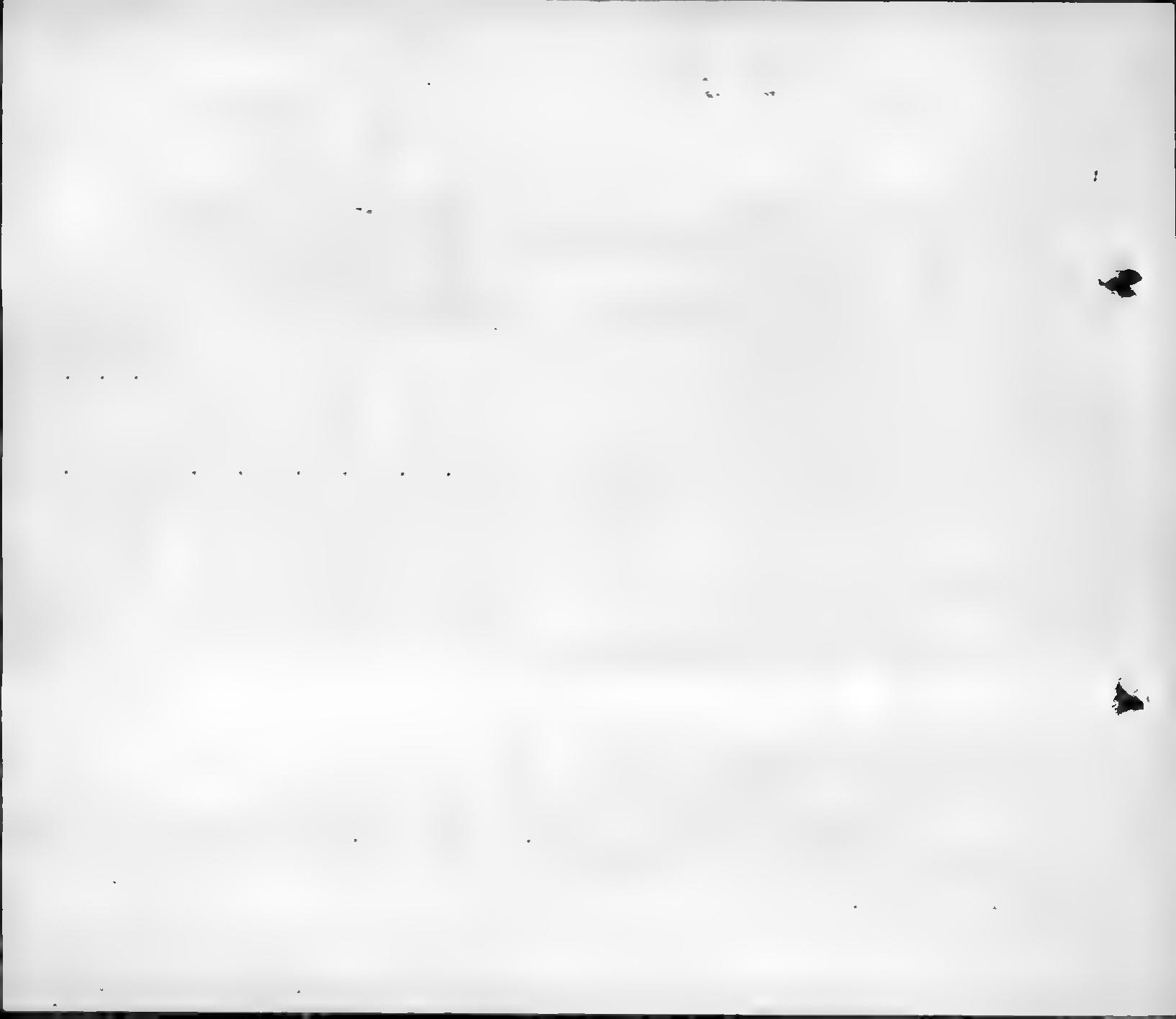
## 23. FUNERAL DIRECTOR

Olm. J. Schenck &amp; Sons. Balto 171

ADDRESS







## MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

Item 9, File 6193

01556

## CERTIFICATE OF DEATH

Reg. Dist. No.

1576

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. PREVIOUS RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Daniels</b>		c. LENGTH OF STAY IN 1b <b>Daniels</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Daniels</b>		d. STREET ADDRESS <b>107 Lower Brick Row</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>107 Lower Brick Row</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>WALTER PATTERSON WHITLEY</b>		First	Middle	Lost	4. DATE OF DEATH <b>Feb. 21</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>1874</b>	9. AGE (in years last birthday) <b>81 60 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cotton Mill Worker</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <b>217-26-6696</b>		17. INFORMANT <b>James Shifflett Rt. 2 Elkton, Va.</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>420.1</b>		DUE TO <b>Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) } DUE TO (c)		<b>Arteriosclerotic Cardio-Vascular Disease</b>		2 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Ellicott City, Md.</b>		(County) <b>Ellicott</b> (State) <b>Md.</b>
21. I certify that I attended the deceased from <b>Jan 10, 1956</b> to <b>Feb. 21, 1956</b> , that I last saw the deceased alive on <b>Feb. 21, 1956</b> , and that death occurred at <b>5 P. M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>William F. Gossaway</b> M.D. ADDRESS (Street, city or town, state) <b>Ellicott City, Md.</b> DATE SIGNED <b>2/21/56</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-24-56</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Good Shepherd</b>		22d. LOCATION (City, town, or county) <b>Ellicott City, Md.</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>F.C. Higinbotham, Ellicott City, Md.</b>								
24a. REC'D. BY REGISTRAR <b>FEB 27 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Mr. Martin</b>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director,  
page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No. 36

## 1. PLACE OF DEATH:

COUNTY Balto. MARYLAND  
 CITY (If outside corporate limits, write RURAL  
 OR and give nearest town)  
 TOWN Catonsville

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS

Paradise Nursing Home

3. NAME OF  
 DECEASED:  
 (Type or Print)

(First)

(Middle)

(Last)

## 5. SEX:

Female

white

10A. USUAL OCCUPATION (Give kind of  
 work done during most of working life,  
 even if retired):housewife10B. KIND OF BUSINESS  
 OR INDUSTRY:at home

## 13. FATHER'S NAME:

John R. Carroll18. WAS DECEASED EVER IN U.S. ARMED FORCES?  
 (Yes, no, or unk.) (If Yes, give war or dates  
 of service)

no

## 18. SOCIAL SECURITY NO.

none

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## IMMEDIATE CAUSE

(A)  
 DUE TOCerebral vascular accidentINTERVAL BETWEEN  
 ONSET AND DEATH

15 minutes

## ANTECEDENT CAUSE (\$)

(B)  
 DUE TODISEASES OR CONDITIONS, IF ANY,  
 GIVING RISE TO THE ABOVE CAUSE  
 STATING UNDERLYING CAUSE LAST.

(C)

Arteriosclerosis, cerebralUnknownII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES  NO 

21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
 (If either, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) (County) (State)  
 INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
 OF INJURY21E. INJURY OCCURRED  
 While  Not while   
 at work  at work 

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-16 1955, to 2-8, 1956 that I last saw the deceased  
 alive on 2-7, 1956, and that death occurred at 3<sup>15</sup>A M, from the causes and on the date stated above.  
 SIGNATURE: Stephen J. Neagess ADDRESS: Catonsville 28 Md DATE SIGNED: 2-8-56

23. BURIAL, CREMATION,  
 REMOVAL (SPECIFY)

Burial

DATE THEREOF: 2/10/56

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county)

(State)

Moreland Mem. Pk.

DATE REC'D BY LOCAL  
 REGISTRAR

REGISTRAR'S SIGNATURE

14. FUNERAL DIRECTOR

ADDRESS

Feb 8, 1956 J. W. Kedrich Wm J. Schinner & Sons Balto. Md.



1578

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR Calverton  
 TOWN Calverton  
 HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS Ridgeview Manor

3. NAME OF  
DECEASED:  
(First)  
(Middle)  
(Last)Bernard W. Wilson

## 4. SEX:

M6. COLOR OR  
RACE:W7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.Widow

## 8. DATE OF BIRTH:

Feb 22, 18984. DATE  
(Month) (Day) (Year)  
OF  
DEATH: Feb 28 19569. AGE last birthday: 78  
IF UNDER 1 YEAR 0 MONTHS  
IF UNDER 24 HRS 0 DAYS  
Months Days Hours Min.10a. USUAL OCCUPATION Give kind of  
work done during most of working life,  
even if retired). Paper Hanger10b. KIND OF BUSINESS OR  
INDUSTRY:11. BIRTHPLACE (State or foreign country): MD 12. CITIZEN OF WHAT  
COUNTRY?

## 13. FATHER'S NAME:

Carl Wilson

## 14. MOTHER'S MAIDEN NAME:

Lorraine Houston15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)

## 16. SOCIAL SECURITY NO.:

## 17. INFORMANT &amp; ADDRESS:

Mr. & Mrs. Wilson in 2830 SouthbrookInterval Between  
Onset And Death  
2 days

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) DUE TO

Congestive Heart Failure

## Antecedent causes (s)

(b) DUE TO

Arteriosclerotic Heart DiseaseDiseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last.

(c) DUE TO

Carcinoma of Prostate

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
-------------------------------------	-----------	--	----------------	----------	---------

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At Work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?
--	--	-----------------------

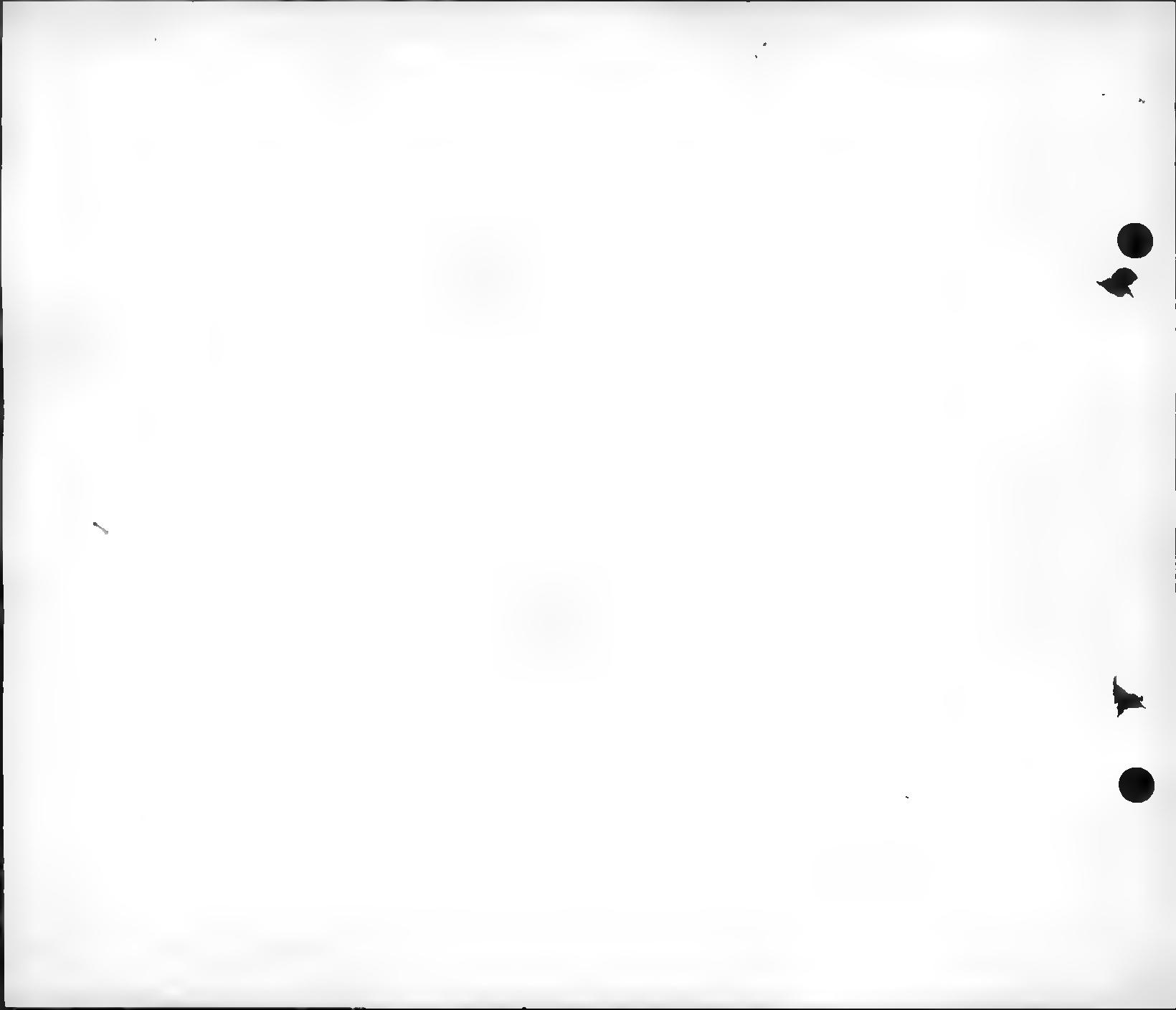
22. I hereby certify that I attended the deceased from Feb 26, 1956 to death, 1956, that I last saw the deceasedalive on Feb 26, 1956, and that death occurred at 7526 Halsted Ave, from the causes and on the date stated above.SIGNATURE Donald Bens

ADDRESS

DATE SIGNED 2/1/56

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF <u>Mar 3/56</u>	NAME OF CEMETERY OR CREMATORIAL <u>Bethel Cem</u>	LOCATION (City, town or County) <u>Calverton</u>	(State) <u>MD</u>
---	---------------------------------	--	---	----------------------

DATE RECD BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <u>W. Neary</u>	24. FUNERAL DIRECTOR <u>Wm. T. F. Home</u>	ADDRESS <u>2112 Dundalk Ave</u>
---------------------------------	--	---	------------------------------------



01559

Reg. Dist. 3

1579  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 3

## 1. PLACE OF DEATH:

COUNTY **Baltimore** MARYLAND  
 CITY (If outside corporate limits, write RURAL  
 OR and give nearest town)  
 TOWN **Reisterstown, Md.** LENGTH OF STAY  
 (in this place)  
 1 Week

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS **Bond Avenue**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Penna.** COUNTY  
 CITY (If outside corporate limits write RURAL and give nearest town)  
 OR  
 TOWN **Philadelphia**

STREET  
 ADDRESS (If rural, give location)  
**4530 Pine Street**

3. NAME OF  
 DECEASED: (First) **Hannah** (Middle) **B.** (Last) **Wilson**

4. DATE  
 OF  
 DEATH **Feb. 20** (Month) **19** (Year) **56**

5. SEX: **F.** 6. COLOR OR  
 RACE: **W.** 7. SINGLE, MARRIED,  
 WIDOWED, DIVORCED,  
 (Specify): **Singled**

8. DATE OF BIRTH: **April 3, 1886**

9. AGE last birthday: **69** IF UNDER 1 YEAR  
 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of  
 work done during most  
 even if retired): **Retired Teacher**

10b. KIND OF BUSINESS OR  
 INDUSTRY:

11. BIRTHPLACE (State or foreign country): **Maryland**

12. CITIZEN OF WHAT  
 COUNTRY? **USA**

## 13. FATHER'S NAME:

**John E. Wilson**

## 14. MOTHER'S MAIDEN NAME:

**Hannah B. Broomall**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  
**No** **no**

16. SOCIAL SECURITY NO.:

## 17. INFORMANT &amp; ADDRESS:

**Fred Wilson Reisterstown, Md.**

18. MEDICAL CERTIFICATION  
 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) **Coronary Occlusion**  
 DUE TO

INTERVAL BETWEEN  
 ONSET AND DEATH

**30. min.**

Antecedent cause(s) (b) **Arteriosclerotic C-V. Disease**  
 Diseases or conditions, if any, DUE TO  
 giving rise to the above cause  
 stating underlying cause last (c)

**3 mos.**

2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.

**none**

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

**none**

**none**

## 20. AUTOPSY?

**Yes**  **No**

(State)

21a. EXTERNAL CAUSE WAS PRIMARY  OR CONTRIBUTING  CAUSE OF DEATH. **None**

21b. PLACE (Home, farm, factory,  
 OF street, office, bldg., etc.) **none**

21c. (City or town) (County)

(State)

**none**

21d. TIME (Month) (Year) (Hour) OF INJURY **none** M. While at work  **Not while**  **On Cork**

## 21e. INJURY OCCURRED

**none**

## 21f. HOW DID INJURY OCCUR?

**none**

22. I hereby certify that I took charge of the remains described above, held an Autopsy  , Inspection  , Inquiry  , and find that death resulted from: Natural causes  , Accident  , Suicide  , Homicide  , Undetermined cause  .

SIGNATURE  
**Z. L. Coplee**

CHIEF MEDICAL EXAMINER  
 DEPUTY MEDICAL EXAMINER  
 M. D. ASSISTANT MEDICAL EXAM.

DATE SIGNED

**2-21-56**

23. BURIAL, CREMATION, REMOVAL (Specify): **Burial**

DATE THEREOF **Feb. 22, 56**

NAME OF CEMETERY OR CREMATORIAL **Elkton Cemetery**

LOCATION (City, town, or county) (State)  
**Elkton Md.**

DATE REC'D BY LOCAL REG. **2-21-56**

REGISTRAR'S SIGNATURE **W. B. Jones**

## 24. FUNERAL DIRECTOR

**J.F. Eline & Son's Reisterstown, Md.**

ADDRESS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

100-100000

Feb

100-100000

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

1580

2411 N. Charles Street, Baltimore

01560

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

Item 9. FilmG193 2-27-56 et.

1. PLACE OF DEATH CITY TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE CITY (If outside corporate limits, write RURAL and give nearest town) TOWN STREET ADDRESS	
County Baltimore Catonsville Paradise Nursing Home		Maryland Length of stay (in this place) Baltimore 706 E. Arlington Ave.	
3. NAME OF DECEASED (Type or Print)	(First) Mary	(Middle) Agnes	(Last) Woods
4. DATE OF DEATH	(Month) Feb. 20, 1956	(Day) 19	(Year)
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
Female	White	Single	Unknown
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Housekeeper	Church Rectory	Baltimore	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
?	Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS	18. MEDICAL CERTIFICATION
no	unknown	James P. Walsh 806 Md. Trust Bldg.	Baltimore, Md.
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>Immediate cause (a) Myocardial failure</p> <p>Antecedent cause(s) (b) Disease or conditions, if any, giving rise to the above cause, stating the underlying cause last</p> <p>(c) Atherosclerotic CVD</p>			
INTERVAL BETWEEN ONSET AND DEATH 72 hrs			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	(COUNTY) (STATE)
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 12-8, 1959, to 2-20, 1956, that I last saw the deceased alive on 2-19, 1956, and that death occurred at 100 P.m., from the causes and on the date stated above.			
SIGNATURE		(Degree or title)	ADDRESS
STEPHEN L. MAGNESS M.D.		CATONSVILLE 28 1/2	2-20-56
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL
Burial		2/23/56	New Cathedral Cem.
LOCATION (City, town, or county) (State)		Baltimore Md.	
DATE REC'D BY LOCAL REG.	REG.	24. FUNERAL DIRECTOR	ADDRESS
Feb. 22, 1956 C. W. Hedinger		John A. Moran 3000 E. Baltimore St	
F. H. Lewis			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01561

Items 8,9 File 6192 2-11-56 et

1581

## CERTIFICATE OF DEATH

Reg. Dist. No. *XX*

## 1. PLACE OF DEATH

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
TOWN Fort HowardLENGTH OF STAY  
(in this place)  
5 DaysHOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Veterans Administration Hospital

3. NAME OF  
DECEASED  
(First)

(Middle)

(Last)

4. DATE (Month)  
OF  
DEATH: February 1(Year)  
1956

5. SEX: Male

6. COLOR OR  
RACE: White7. SINGLE, MARRIED,  
WIDOWED, DIVORCED  
(Specify) Married8. DATE OF BIRTH:  
July 8, 19189. AGE last birthday:  
8710. USUAL OCCUPATION (Give kind of  
work done during most of working life)  
even if retired):11. KIND OF BUSINESS  
OR INDUSTRY:  
Tool & die Maker Tool & Die Co.12. CITIZEN OF WHAT  
COUNTRY?  
U. S. A.

13. FATHER'S NAME:

Sherman L. Wood, Sr.

14. MOTHER'S MAIDEN NAME:

Emma Deming

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.)(If Yes, give war or dates  
of service) WW II

16. SOCIAL SECURITY NO.

219-07-4592

17. INFORMANT &amp; ADDRESS:

Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

ANTECEDENT CAUSE (8)

DISEASES OR CONDITIONS, IF ANY,

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST.

(A) DUE TO

(B) DUE TO

(C) DUE TO

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING

TO THE DEATH BUT NOT RELATED TO THE

DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING  CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory,

OF INJURY street, office bldg., etc.)

(State)

21C. WHERE DID (City or town)

INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)

OF INJURY

21E. INJURY OCCURRED

While Not while at work at work 

21F. HOW DID INJURY OCCUR?

VA M.

22. I hereby certify that  attended the deceased from Jan. 27, 1956 to Feb. 1, 1956 

and that death occurred at 4:30 P.M. from the causes and on the date stated above.

SIGNATURE *Mark*DATE SIGNED *2/2/56*

D. D. MARK, M.D.

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

Burial

DATE THEREOF *2-6-56*

NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county) *Baltimore National*(State) *Baltimore, Maryland*

DATE REC'D BY LOCAL

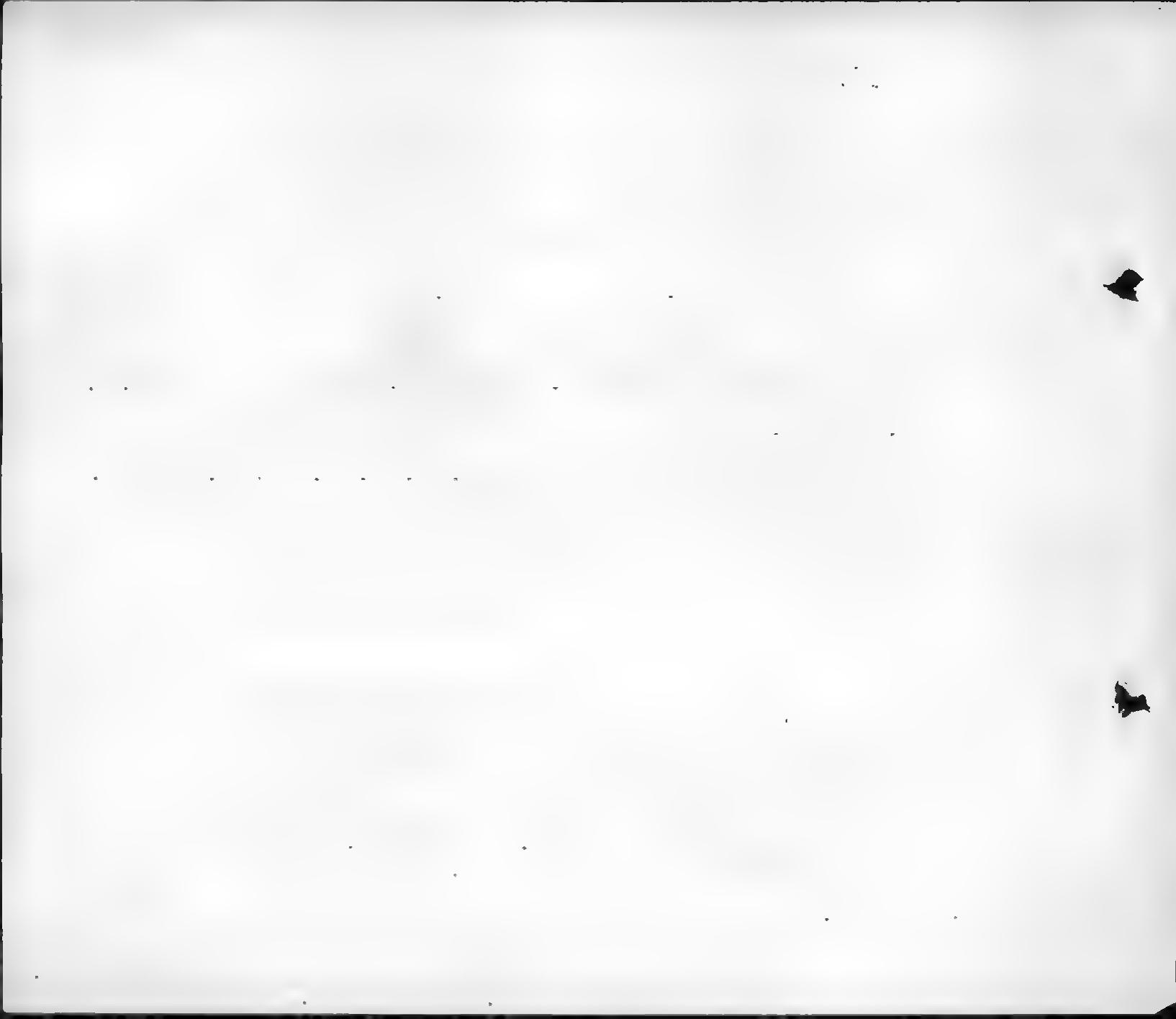
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS Md.

Wm. Cook-Blight, Inc., 6069 Harford Road, Balto.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the words "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**1582 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

01562

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore Ore Mar Steamship		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point Ore Dock		c. LENGTH OF STAY IN 1b 20 hrs.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE				
3. NAME OF DECEASED (Type or print) WORNANEN		First Jacob	Middle			
		Last Wornanen	4. DATE OF DEATH 2-29-56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-26-92			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		10b. KIND OF BUSINESS OR INDUSTRY Steamship	11. BIRTHPLACE (State or foreign country) Unknown			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 216-12-8837	17. INFORMANT Records of ore steamship co.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion						
DUE TO						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)						
DUE TO						
(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. NONE				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>						
ACTUAL SIGNATURE 727 B Davis		DATE SIGNED Feb 29-56				
EXAMINER'S NAME (Type) M. B. Davis, M.D.		MD CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 2/56		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Moreland Mem.	22d. LOCATION (City, town, or county) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Philip Herzig Son		24a. REC'D BY REGISTRAR Oleander & MAR 2 1956		24b. REGISTRAR'S SIGNATURE Dawson L. Parker		

Y. S.

Y. S.

Y. S.

Y. S.





## 1584 CERTIFICATE OF DEATH

Reg. Dist. No. *2*

## 1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)LENGTH OF STAY  
(in this place)

TOWN Baltimore

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS 3801 Locheam Drive

## 3. NAME OF (First)

(Middle)

(Last)

4. NAME OF  
DECEASED:  
(Type or Print)

John

Odgers

Young, Sr.

5. SEX Male

6. COLOR OR  
RACE: White7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify)8. DATE OF BIRTH  
Married

Apr. 18, 1892

9. AGE last birthday  
63 yrs.10. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired). President - Progressive Brass Di11. KIND OF BUSINESS  
OR INDUSTRY: Phila., Pa.12. CITIZEN OF WHAT  
COUNTRY?

## 13. FATHER'S NAME:

William H. Young

14. WAS DECEASED EVER IN U.S. ARMED FORCES  
(Yes, no, or unk.) If Yes, give war or dates  
of service)

15. SOCIAL SECURITY NO.

16. MEDICAL CERTIFICATION  
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

581.0

IMMEDIATE CAUSE

(A)  
DUE TO

Coronary Occlusion

INTERVAL BETWEEN  
ONSET AND DEATH  
3 hrs

ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.(B)  
DUE TO

Hypertension, Coronary Disease

(C)

Coronary &amp; Fever

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES  NO 21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory  
OF INJURY street, office bldg., etc)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year)  
OF INJURY21E. INJURY OCCURRED  
While  Not while   
at work  at work 

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1956, to Feb., 1956, that I last saw the deceased  
alive on Feb. 7, 1956, and that death occurred at 6:25 PM, from the causes and on the date stated above.  
SIGNATURE *Thos. J. Abbott* ADDRESS *4509 Liberty Heights* DATE SIGNED *2-11-56*23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)  
Entombment

DATE THEREOF

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county)

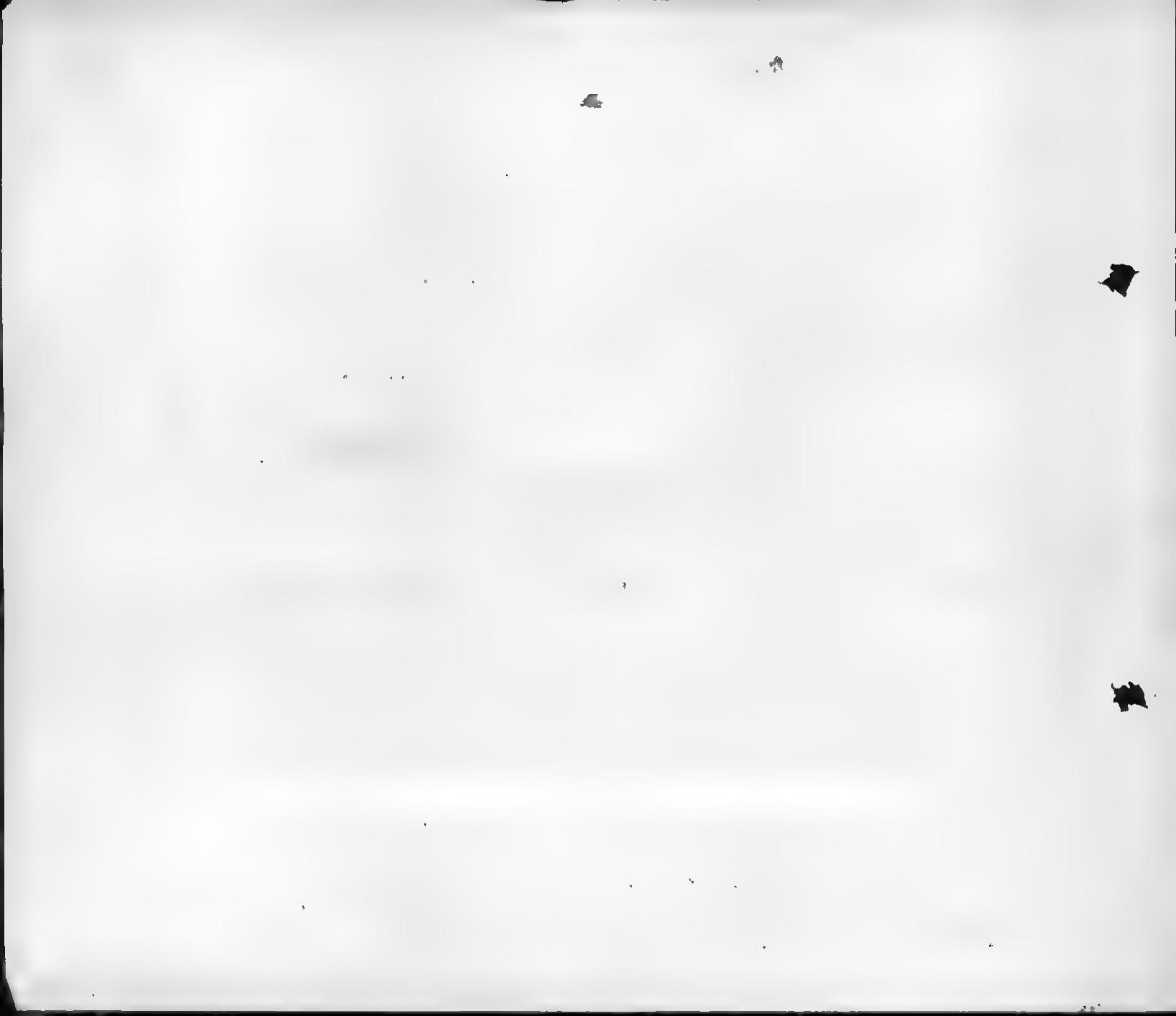
(State)

Feb. 13, 1956

Lorraine Mausoleum

Baltimore, Md.

DATE REC'D BY LOCAL  
REGISTRAR *John J. Abbott* - 58REGISTRAR'S SIGNATURE *John J. Abbott*24. ESTATE DIRECTED  
TO *Ellsworth Armacost* ADDRESS  
*4600 Liberty Heights, Ave.*



## 1585 CERTIFICATE OF DEATH

Reg. Dist. No. 38

Items 9, 13, 14 Film GI 3 3-9-56 et

## 1. PLACE OF DEATH:

COUNTY	Baltimore	MARYLAND
CITY (If outside corporate limits, write RURAL or and give nearest town)	RURAL LENGTH OF STAY (in this place)	
TOWN	Rural: Towson	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Eudowood Sanatorium Towson 4, Maryland	

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE	MD	COUNTY	Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town)	Baltimore City 3 Vol 1-14		
STREET ADDRESS	219 W. Mulberry St.		

## 3. NAME OF DECEASED: (Type or Print)

First) Tom

(Middle)

(Last) Yuen

4. DATE OF DEATH: (Month) (Day) (Year)

2 27 1956

## 5. SEX:

6. COLOR OR RACE: yellow

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: 9/9/1880

9. AGE last birthday: IF UNDER 1 YEAR

Months Days Hours Min.

11875 yrs.

10a. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired.

10b. KIND OF BUSINESS OR INDUSTRY: Chinese Restaurant

11. BIRTHPLACE (State or foreign country): China

12. CITIZEN OF WHAT COUNTRY? China

## 13. FATHER'S NAME:

Unknown

## 14. MOTHER'S MAIDEN NAME:

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

## 17. INFORMANT &amp; ADDRESS:

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

002X  
Immediate cause

(a) DUE TO

Conditions decompensation.

Interval Between  
Onset And Death

3 mos.

Antecedent causes (s)  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

Pulmonary tuberculosis.

(7).

(c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, of office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 2/27/1956, to 2/27/1956, that I last saw the deceased

alive on 2/27/1956, and that death occurred at 5:20 PM, from the causes and on the date stated above.

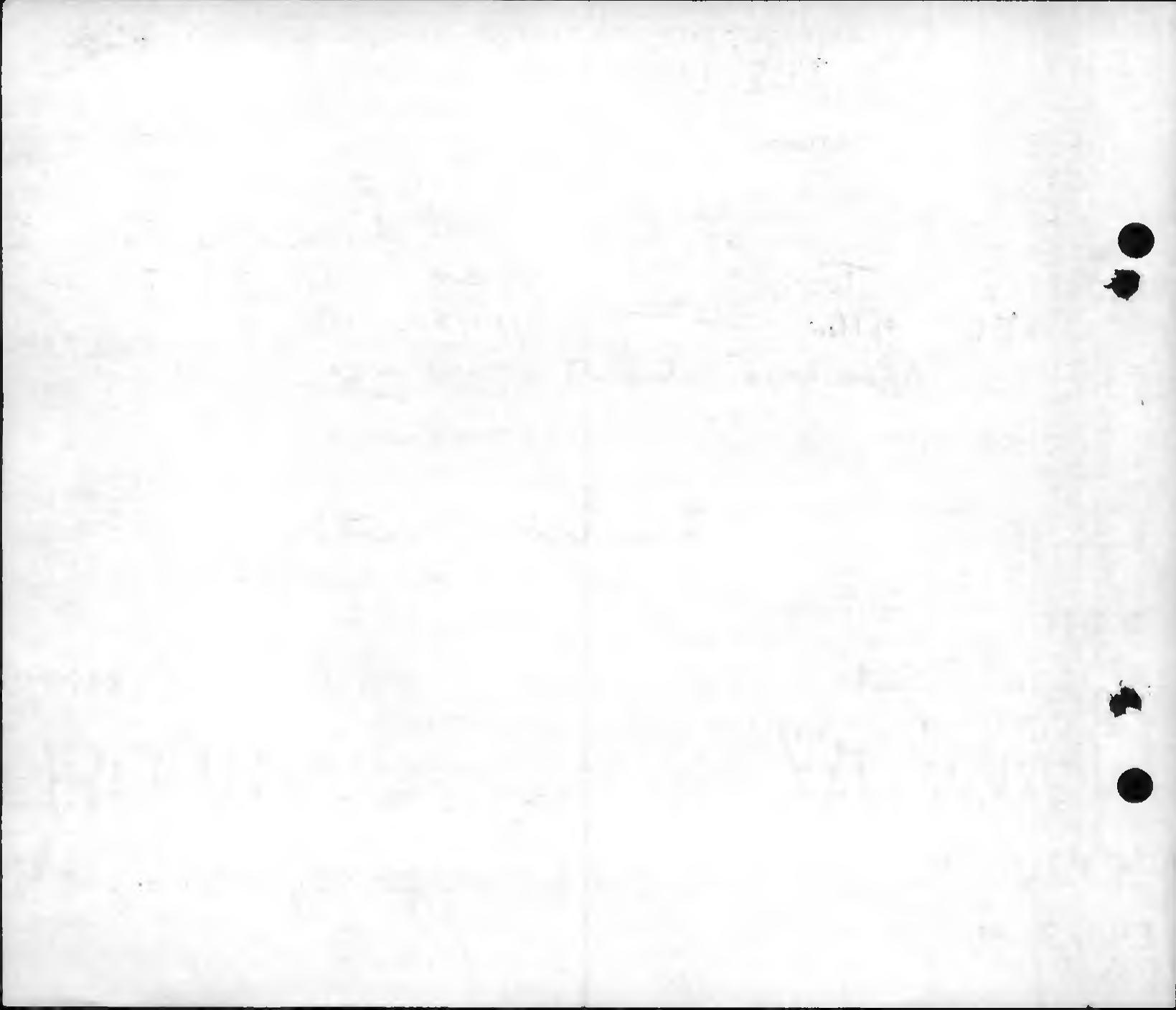
SIGNATURE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)
Burial	2/29/56	Lorraine	Baltimore	Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
2/28/56	CCN	Clyde M. Morris	108 W. 10th St.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 45

## 1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR  
and give nearest town)  
TOWNLENGTH OF STAY  
(In this place)HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

107 Kingston Road

3. NAME OF  
DECEASED:  
(Type or Print)

(First)

(Middle)

(Last)

4. SEX:  
Female6. COLOR OR  
RACE:  
White7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify):

Zeigler

8. DATE OF BIRTH:  
Oct 10-19549. AGE last birthday:  
16 yrs.10. IF UNDER 1 YEAR  
Months Days Hours Min.

11. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
even if retired):10b. KIND OF BUSINESS OR  
INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT  
COUNTRY?

13. FATHER'S NAME:

George L. Zeigler

14. MOTHER'S MAIDEN NAME:

Mildred Morgan

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)

16. SOCIAL SECURITY NO.:

17. INFORMANT &amp; ADDRESS:

Parents above

18. MEDICAL CERTIFICATION  
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a)  
DUE TO

Suppurative Otitis Media, Left.

INTERVAL BETWEEN  
ONSET AND DEATH

Antecedent cause(s)

Diseases or conditions, if any, (b)  
giving rise to the above cause DUE TO  
stating underlying cause last (c)II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes  No 21a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING  CAUSE OF DEATH.21b. PLACE (Home, farm, factory,  
OF street, office bldg., etc.,  
INJURY)

21c. (City or town) (County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY M.21e. INJURY OCCURRED  
While at Not while  
work  at work 

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and  
find that death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined cause   
SIGNATURE *Paul F. Menn*CHIEF MEDICAL EXAMINER  
DEPUTY MEDICAL EXAMINER  
M. D. ASSISTANT MEDICAL EXAM.DATE SIGNED  
2/20/5623. BURIAL, CREMATION,  
REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county)

(State)

Burial  
DATE REC'D BY LOCAL  
REG. 2/20/56

REGISTRAR'S SIGNATURE

Edith Harley

24. FUNERAL DIRECTOR

ADDRESS

John S. Connolly Essex

BUREAU V. S.

FEB 29 1956

RECEIVED